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A Call for Action

THE PEPPER COMMISSION

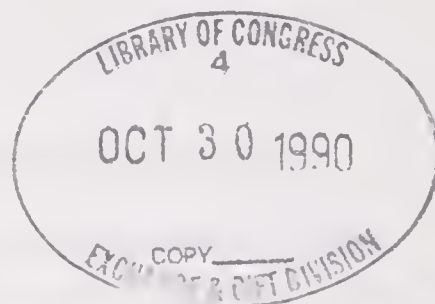
U.S. Bipartisan Commission
on Comprehensive Health Care

Supplement to the Final Report

September 1990



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A Call for Action

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U.S. Bipartisan Commission
on Comprehensive Health Care

Supplement to the Final Report
September 1990

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TABLE OF CONTENTS

Page

HEALTH CARE

| | |
|--|-----|
| West Germany's Health-Care and Health-Insurance System: Combining Universal Access With Cost Control—Uwe E. Reinhardt, Ph.D..... | 3 |
| Europe's Decentralized and Semi-Private Health Insurance—William A. Glaser | 19 |
| Controlling Health Care Costs—Mark Merlis..... | 27 |
| Medical Malpractice—Paul Weiler and Troyen A. Brennan..... | 43 |
| Design of Health Plan Benefits for the Nonelderly—Janet Lundy | 57 |
| Preventive Health Services—Melvina Ford and Mark Merlis | 67 |
| Health Benefits for Treatment Services for Substance Abuse and Mental Illness—Edward Klebe..... | 79 |
| Quality Assurance: A Comprehensive, National Strategy for Health Care Is Needed—General Accounting Office | 93 |
| Primary Care Service Delivery Programs—A Critical Element to Ensuring Access to Care—Bonnie Lefkowitz and Judy Rodgers | 105 |
| Limiting Favored Tax Treatment for Employee Health Insurance—Marilyn Moon, Ph.D. | 121 |
| Fewer Resources, Greater Burdens: Medical Care Coverage for Low-Income Elderly People—Diane Rowland, Sc.D..... | 125 |

LONG-TERM CARE

| | |
|--|-----|
| Case Management in Long-Term Care—Office of Technology Assessment..... | 149 |
| Role of Federal and State Governments and Voluntary Organizations in Assuring Quality of Care in Selected Long-Term Care Services—Carol O'Shaughnessy and Richard Price..... | 161 |
| Due Process: Review and Appeal Procedures in Long-Term Care—Jane Handler Yurow..... | 173 |

STAFF MEMORANDA AND BRIEFING PAPERS

| | |
|---|-----|
| Canada's Health Care System: Questions Americans Should Ask | 217 |
| Financing Long-Term Care in Canada..... | 219 |
| Comparing Health Care Financing Across Nations: A Summary..... | 221 |
| Comparing Financing and Delivery of Long-Term Care Across Nations: A Summary | 223 |
| Canadians' Use of the American Health Care System..... | 225 |
| Comparison of Selected Comprehensive Health Plans..... | 227 |
| An Overview of Issues in Estimating the Market Potential for Private Long-Term Care Insurance.... | 231 |
| Converting Life Insurance Benefits to Long-Term Care Benefits | 237 |
| Adding a Long-Term Care Option to Medicare..... | 239 |

LIST OF TABLES

Table

Page

HEALTH CARE

West Germany's Health-Care and Health-Insurance System: Combining Universal Access With Cost Control

| | | |
|---|--|----|
| 1 | Alternative Mixes of Health-Insurance and Health-Care Delivery | 4 |
| 2 | Selected Demographic Data—United States and West Germany, 1985 | 5 |
| 3 | Variance in the Payroll-Tax Rate Across West German Sickness Funds, 1988 | 15 |

Primary Care Service Delivery Programs—A Critical Element to Ensuring Access to Care

| | | |
|---|---|-----|
| 1 | How Increased Reimbursement Affects Capacity and Services in C/MHCs | 119 |
|---|---|-----|

Fewer Resources, Greater Burdens: Medical Care Coverage for Low-Income Elderly People

| | | |
|----|--|-----|
| 1 | Distribution of the Elderly Population by Poverty Level, 1988 | 127 |
| 2 | Distribution of the Elderly Population by Income Level and Selected Characteristics, 1988..... | 128 |
| 3 | Characteristics of the Elderly Population by Income, 1988..... | 129 |
| 4 | Health Status, Medical Conditions and Other Related Problems of the Elderly Population, 1984..... | 131 |
| 5 | Health Insurance Coverage of the Elderly Population, 1988..... | 131 |
| 6 | Health Insurance Coverage of the Elderly Population by Income, 1988..... | 132 |
| 7 | Medicaid Income Eligibility Limits for Elderly Individuals, 1989..... | 134 |
| 8 | Medicaid Income Eligibility Limits for Elderly Couples, 1989..... | 135 |
| 9 | Medicaid Resource Eligibility Limits for the Elderly Population, 1989..... | 136 |
| 10 | Use of Physician Services and Prescription Drugs by the Elderly Population by Insurance Coverage, 1987 | 137 |
| 11 | Cost-Sharing Liabilities for Elderly Medicare Enrollees Resulting From the Use of Medicare Services, 1990 | 139 |
| 12 | Out-of-Pocket Spending for Medical Care by the Elderly Population, 1989..... | 140 |
| 13 | The Impact of Medicaid on Out-of-Pocket Spending for Medical Care by Low-Income Elderly People, 1989..... | 142 |
| 14 | Shifts in Poverty Status Due to Medical Expenses..... | 142 |
| 15 | Number of New Eligibles Assisted by Proposal to Expand Medicaid Coverage of the Low-Income Elderly Population, 1990..... | 144 |
| 16 | Cost of Proposal to Expand Medicaid Coverage of the Low-Income Elderly Population, 1990..... | 144 |

LIST OF FIGURES

Figure

Page

HEALTH CARE

West Germany's Health-Care and Health-Insurance System: Combining Universal Access With Cost Control

| | | |
|---|---|----|
| 1 | Direct Health-Care Expenditures, 1975-86..... | 5 |
| 2 | Sources and Uses of Direct Health Care Expenditures | 6 |
| 3 | The Structure of the West German Health Insurance System | 8 |
| 4 | Alternative Financial Arrangements Between Patients, Providers and Third-Party Payers | 12 |
| 5 | Average Premium in the Statutory Health Insurance System | 13 |

Fewer Resources, Greater Burdens: Medical Care Coverage for Low-Income Elderly People

| | | |
|----|---|-----|
| 1 | Distribution of the Elderly Population by Poverty Level, 1988 | 127 |
| 2 | Percent of Elderly Who Are Poor or Near-Poor by Sex, Race, Age and Living Arrangement, 1988 | 128 |
| 3 | Percent of Elderly People Reporting Fair or Poor Health by Income, 1984..... | 130 |
| 4 | Percent of Elderly Population With Selected Conditions, 1984..... | 130 |
| 5 | Health Insurance Coverage of Elderly People, 1988..... | 131 |
| 6 | Health Insurance Coverage of Elderly People by Income, 1988 | 132 |
| 7 | State Medicaid Eligibility Criteria for Elderly Individuals, 1989 | 133 |
| 8 | Utilization of Physician Services by the Elderly Population by Insurance Coverage, 1987..... | 137 |
| 9 | Utilization of Prescription Drugs by the Elderly Population by Insurance Coverage, 1987..... | 138 |
| 10 | Hospitalization Rates for Selected Groups of Elderly People, 1984..... | 138 |
| 11 | Medicare Benefits and Cost-Sharing Liabilities for Hospital and Physician Services, 1990..... | 139 |
| 12 | Out-of-Pocket Expenses for Medical Care as a Percent of Per Capita Income, 1986..... | 140 |
| 13 | Components of Out-of-Pocket Spending for Medical Care, 1989..... | 140 |
| 14 | Percent of Elderly People With Out-of-Pocket Spending for Acute Care Exceeding 15 Percent of Income, 1986 | 141 |
| 15 | Out-of-Pocket Spending as a Percent of Income for Low-Income Elderly People by Hospital Use and Insurance Coverage, 1986..... | 141 |
| 16 | The Impact of Medicaid on Out-of-Pocket Spending for Medical Care by Low-Income Elderly People, 1989..... | 142 |
| 17 | Poverty Among Elderly People Before and After Medical Expenses..... | 143 |

Health Care

WEST GERMANY'S HEALTH-CARE AND HEALTH-INSURANCE SYSTEM: COMBINING UNIVERSAL ACCESS WITH COST CONTROL

Uwe E. Reinhardt, Ph.D.*

INTRODUCTION

As the United States struggles with its twin problems in health care—providing the nation's low-income families with access to adequate health care, and controlling the cost of health care—it is natural to explore how other nations have tried to address these problems.

The United States now spends slightly 11 percent of its GNP on health care. Most other industrialized nations spend only about 6 to 9 percent. Yet all of these nations have succeeded in extending comprehensive health insurance coverage to all of their citizens, a goal that has so far eluded the United States for some 30 to 35 million Americans.

These remarkable differences in spending and insurance coverage lead one to wonder (1) how other nations manage to enjoy universal insurance coverage and yet keep their outlays on health care so low, (2) precisely what additional benefits Americans actually receive for their much larger spending on health care and (3) what, if any, features of health systems abroad might be grafted upon the American health system.

In searching for answers to these questions Americans have looked chiefly to their northern neighbor. Numerous articles and monographs have recently appeared on the strengths and shortcomings of Canada's government-financed health system, and no American health-care conference has considered itself complete without at least one session on the Canadian system.

The West German health system, however, may furnish an even more instructive data point from the American perspective. That system represents an at-

tempt to achieve horizontal equity in the distribution of health care and fairly good control over total health care expenditures without a complete takeover of the health-insurance system by the government. The chief policy instruments used to that end are (1) tight, statutory regulation of a network of self-governing, self-financing sickness funds that observe substantially identical methods and schedules for compensating the providers of health care, and (2) use of health-insurance premiums, rather than taxes and transfers, to redistribute income from relatively healthy or high-income groups to relatively sick or low-income groups.

Table 1 illustrates the position of West Germany's health system in the spectrum from purely governmental to purely private health care. That table makes a clear distinction between the production and the financing of health care, a distinction not usually made by observers who tends to lump together all foreign health-care systems under the derogatory label *socialized medicine*.

Strictly speaking, the term *socialized medicine* should be reserved for health systems in which the government operates the production of health care and provides its financing (i.e., systems in Cell A of the table). Great Britain and most of the Nordic countries of Europe fit that label, as do the health systems operated by the U.S. Department of Veterans Affairs and by the Department of Defense.¹

By contrast, one would not call Canada's health system "socialized medicine" on that definition, because Canada's system combines socialized (government) financing of health care with a pluralistic,

* Report prepared for the U.S. Bipartisan Commission on Comprehensive Health Care by Uwe E. Reinhardt, Ph.D., James Madison Professor of Political Economy, Princeton University, August 30, 1989, Revised June 25, 1990.

¹ It is no small irony that President Eisenhower, a staunch opponent of *socialized medicine*, actually spent the bulk of his adult life in Box A of Table 1, that is, relying on purely *socialized medicine*. Many American Congressmen and -women as well as Senators also rely on *socialized medicine* for their health care.

partly private and partly public delivery system that extends over all three rows in Table 1. Nor does the West German health system fit the label of *socialized medicine*.

Table 1 Alternative Mixes of Health-Insurance and Health-Care Delivery

| Production and Delivery | Collectivized (Socialized) Financing of Health Care | | | Direct Financing |
|---------------------------------|---|------------------------------|------------------------------|---|
| | Government Financed Insurance | Private Health Insurance * | | Out of Pocket by Patients at Point of Service |
| | | Within a statutory framework | Within an unregulated market | |
| Purely Government Owned | A | D | G | J |
| Private Not-for-Profit Entities | B | E | H | K |
| Private For-Profit Entities | C | F | I | L |

| | |
|----------------------------|-------------------------------|
| The Canadian Health System | The West German Health System |
|----------------------------|-------------------------------|

* Note: Technically, whenever the receipt of health care is paid for by a third party rather than by the recipient at point of service, it is financed out of a *collective* pool and is thus "socialized" financing. In this sense, private health insurance is just as much "collectivist" or "socialized" as is government-provided health insurance. Both forms of financing destroy the normal working of a market, because both eliminate the individual benefit-cost calculus that is the sine-qua-non of a proper market.

West Germany's health system is concentrated in rows D, E and F of Table 1. It is even further removed from bona fide socialized medicine than is Canada's health system, because both the production and the financing of health care in that country are pluralistic (although both facets are rather tightly constrained by Federal statutes). At this time, for example, only about 12 percent of total direct health-care expenditures in West Germany is paid for directly out of public budgets. The comparable American number is 42 percent.

It is probable that the American health system will eventually stumble toward an arrangement that will resemble West Germany's in important respects, with a tightly regulated, private health-insurance industry taking the place of West Germany's sickness funds. The scenario might be the following. Given the emerging pressures in the American economy, both the federal and the state and local governments are likely to continue in their attempts to procure health care for publicly insured patients at fees below the providers' full cost, leaving private business—particu-

larly small business firms with weak market power—to furnish proportionately more of the providers' revenue. At the same time, the public sector is likely to shift financial responsibility for low-income, uninsured working Americans onto the shoulder of private business by *mandating* employer-paid health insurance. In return, the business sector—once again, particularly small business firms—can be counted on to ask for mandated open enrollment and community-rating, on the underwriting side of health insurance, and for common fee schedules applying to all payers, on the reimbursement side. That system would occupy cells D, E and F in Table 1.

The remainder of this report provides a synopsis of West Germany's health system, with primary emphasis on the insurance facet. The first section below is confined to the country's health-care delivery system. The West German health-insurance system is described in the following section. The last section concentrates on insights Americans might draw from the West German experience.

THE WEST GERMAN HEALTH-CARE DELIVERY SYSTEM

West Germany currently has a population of 61 million. That population is, on average, much older than that of the United States. In 1985, for example, only 15 percent of West Germany's population was younger than 15 years; the comparable American figure was 22 percent. On the other hand, close to 15 percent of the West German population in that year was older than 65 years, compared with only 12 percent of the American population. Table 2 presents these and other demographic data.

If the much older West German population were served by an American-style health-care financing and delivery system, the country obviously would have to spend much more on health care than does United States at this time, because the average per-capita health expenditures of older persons exceeds that of younger persons by a factor of 2 to 3. In fact, however, West Germany somehow succeeds in spending considerably less on health care than does the United States, as is shown in Figure 1. Total direct spending on health services and supplies amounted to less than 8 percent in West Germany during 1986, but to over 10 percent in the United States.²

² These numbers differ from the 11 percent or so that "national health expenditures" in the United States are said to be taking of "gross national product." The category of "direct expenditures on health services and supplies" excludes certain public health activities of the government, medical research, and construction of medical facilities, all of which are included in the

Table 2 Selected Demographic Data—United States and West Germany, 1985

| Statistic | United States | West Germany |
|---------------------------------|------------------|--------------|
| Total Population | 240 million..... | 61 million |
| —percent under 15 years of age. | 22% | 15% |
| —percent over 65 | 12% | 15% |
| Life Expectancy: | | |
| —male | 71.1 years | 71.2 years |
| —female | 78.3 years | 77.8 years |
| Infant Mortality Rate * | 10.6/1000 | 9.6/1000 |

* Deaths of children one year or younger, per 1,000 live births; 1984.

SOURCE: Schneider, Sommer and Kececi (1987), tables F.2.2.1 and F.8.2.1.

Yet one does not often hear talk of rationing in West German health care—certainly not nearly as often as that issue is raised in the United States. West Germany has more physicians per capita than does the United States, and also more hospital beds. The country prides itself on its advanced, research-oriented pharmaceutical industry and on its reliance on high-tech medicine, which reaches into the practice of most private practitioners. There is some evidence that a variety of high-cost, high-tech medical technologies are more abundantly available in the United States than they are in West Germany. But stories of “patient-dumping” or of poor patients who are denied access to available health care simply for want of ability to pay—a regular feature now in America’s daily press—are completely unknown in West Germany. Such stories would horrify West Germans and undoubtedly would bring swift remedial action by government.

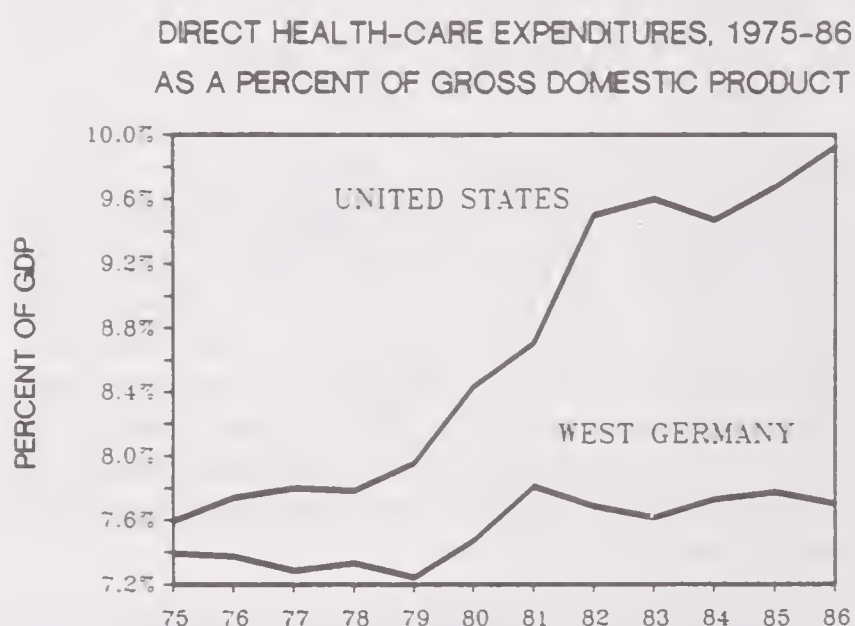
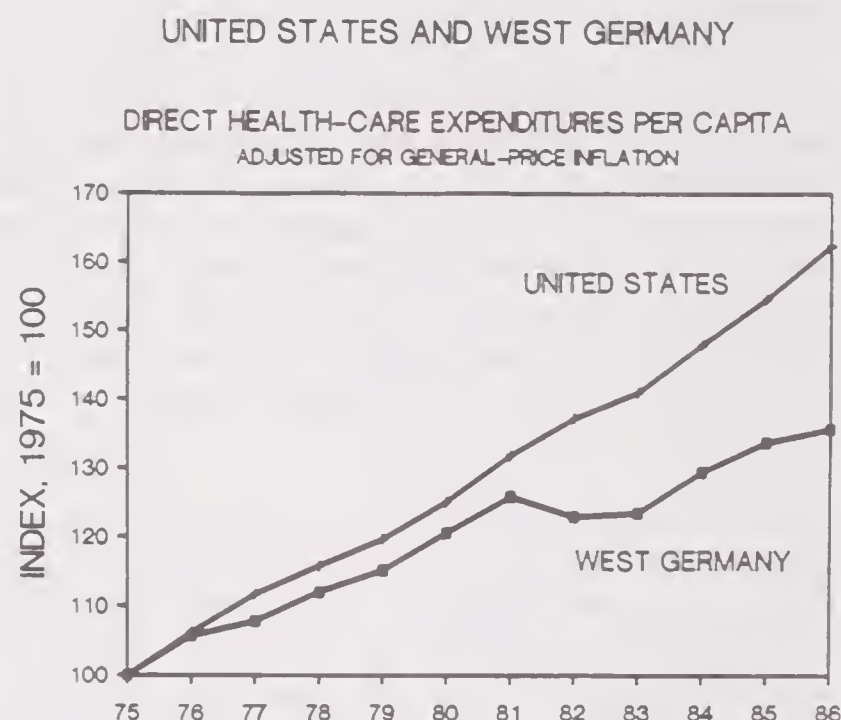
The West German health-care delivery system represents a pluralistic mix of private medical practices and both private and publicly owned inpatient facilities among which patients typically may choose freely.

Of West Germany’s roughly 150,000 active physicians (about 245 physicians per 100,000 populations, compared with a comparable number of 220 in the United States), about 67,000 or 45 percent work in private, office-based ambulatory practice among whom patients have free choice. These physicians are compensated for their services on a fee-for-service basis, according to a predetermined and binding fee schedule that is negotiated between regional associa-

broader definition of “national health expenditures.” The term “gross domestic product” refers to the total output produced within a nation’s boundaries, whether by nationals or foreigners residing within these boundaries. By contrast, the term “gross national product” refers to the total output produced by a nation’s citizens, within the nation’s boundaries or abroad. In practice, the two national output measures do not differ substantially in magnitude.

tions of physicians and health-insurers, as will be described further on.

Figure 1 Direct Health-Care Expenditures, 1975–86 *



* Excludes Administrative Costs, Research and Construction.

SOURCE: Schneider, Sommer and Kececi (1987).

Under the strict, statutory dividing line between ambulatory and inpatient care imposed by German law, physicians in ambulatory practice do not follow their patients into the hospital after they have referred a patient there, as is the custom in the United States. Instead, all inpatient physician services are rendered by the 80,000 or so hospital-based physicians who are salaried employees of their hospital. Among these hospital-based physicians, only the chiefs have the privilege of seeing private patients on both an ambulatory and an inpatient basis.

West Germany has about 11 hospital beds per 1,000 population, which is about twice the comparable American number. Close to half of all West German hospitals beds are in publicly owned facilities, mainly municipal hospitals. Another 35 percent of beds are in private, not-for-profit community hospitals, and close to 13 percent are in privately owned, for-profit facilities.

As a rule, the capital budgets of West German hospitals—even of privately owned, for-profit hospitals—are furnished by the state governments, subject to a regional plan. The operating funds of hospitals, on the other hand, come from the nation’s health insurance system in the form of predetermined per diems that are negotiated by each hospital separately with regional associations of health insurers, under an all-payer-system.

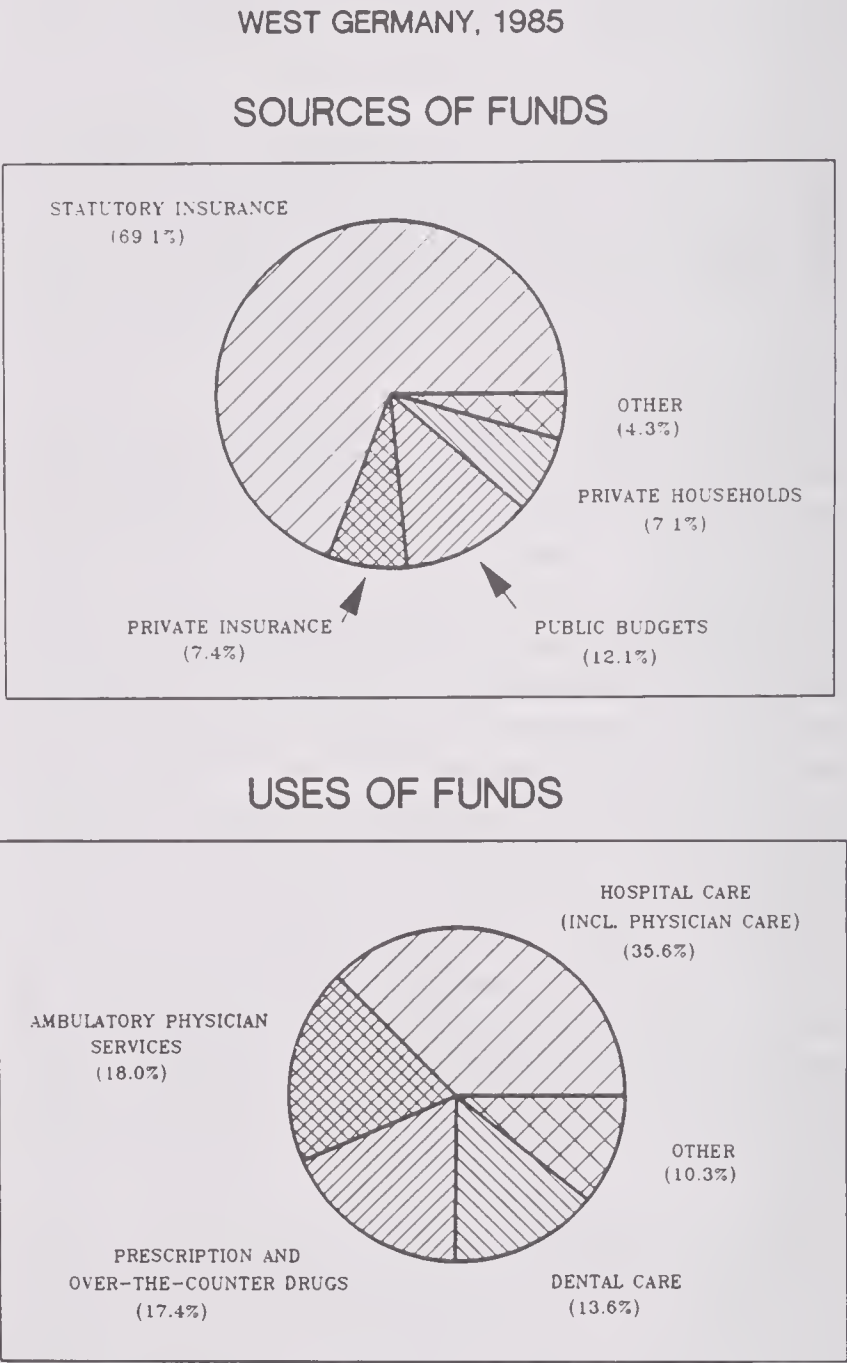
At this time, the average cost per inpatient day in West Germany is about DM 300 (\$ 180), although there is some variation about this average, depending on the type and location of the hospital. About 15 percent of the total per-diem cost represents the salary of hospital-based physicians. An inclusive per-diem cost of \$ 180 or so may seem extremely low by American standards, but it is not strictly comparable to the American per diem cost, because the average length of stay in West German hospitals is over twice the American average. Part of that differential reflects the widespread use of West German hospital beds for long-term care. But average length of stay in West Germany is close to twice the American average even for well defined cases, such as a normal vaginal delivery. The average patient-day in West German hospitals is thus not at all the same as is an American inpatient-day. Even so, it might be very interesting for Americans to study the West German hospital industry more closely to ascertain whether significant cost differentials remain even after adjustment for case-mix and length of stay.

Figure 2 presents compact data on the sources and uses of direct health-care expenditures in West Germany. The Statutory Health Insurance system accounts for about 70 percent of these outlays and private health insurance only about 7.4 percent. In contrast to the United States, where over 40 percent of direct health-care expenditures now flow through government budgets, only about 12 percent of West German health expenditures come directly from government budgets.

It will be noted that the West German hospital sector absorbs only about 36 percent of total direct health expenditures, and that figure includes the salaries of the country’s over 80,000 hospital-based physi-

cians. By contrast, in 1987, hospitals absorbed about 44 percent of total direct health-care spending in the United States, a figure that excludes the bulk of inpatient services rendered by physicians. The American statistic, however, does include the services of outpatient departments which are largely absent from the West German scene, because ambulatory care is by statute the domain of the country’s private medical practitioners.

Figure 2 Sources and Uses of Direct Health Care Expenditures *



* Excludes Administrative Costs, Research and Construction.
 SOURCE: Schneider, Sommer and Kecici (1987), pp. 278-9.

Finally, it will be noted in Figure 2 that private households in West Germany pay directly out of pocket for only about 7 percent of total direct health-care expenditures, mainly for over-the-counter drugs and appliances (for example eye glasses) of a higher quality than that fully covered by health insurance. In general, West Germans bear few if any out-of-pocket

expenses for health care at the time such care is received. By contrast, American households pay directly out of pocket some 26 percent of total direct health expenditures, which is the highest degree of cost sharing by patients in the industrialized world. This circumstance may come as a surprise to those who view excessive health-insurance coverage as the main culprit behind America's high health-care expenditures.

A quite unique feature of the West German health system is the so-called "Concerted Action" (*Konzertierte Aktion*), an annual assembly of all of the stakeholders in the country's health care system. This annual assembly was mandated by Federal law in 1977. It includes representatives of the associations of all of the providers (including pharmacists), of the Statutory and private health insurance carriers, of the pharmaceutical industry, of the major unions and associations of employers, and representatives of the state and local governments. It is the task of this assembly to establish annually broad, national guidelines for the economic development of the health care system, among them the overall growth in expenditures relative to the expected growth of the Gross National Product (GNP).

The assembly was intended by government to serve as a consensus-building device. It does not have governmental powers. For example, the guidelines it establishes are not legally binding upon any of the parties; they merely serve as benchmarks for negotiations over fees, prices and per diems of health services that take place annually at the state level between associations of insurers and of providers. The assembly has, so far, carried forward its work with varying success, but is generally credited with having had some constraining effect on negotiations at the lower level. Furthermore, its work is widely covered in the media.

WEST GERMANY'S HEALTH INSURANCE SYSTEM

Virtually the entire West German population has comprehensive health insurance coverage for a very broad range of benefits that includes ambulatory physician care, all inpatient care, prescription drugs, dental care, medical supplies and appliances, and even recreational stays (the so-called *Kuren*) in health spas following major bouts of illness or merely a state of exhaustion. With minor exceptions, the covered services are made available to patients free of coinsurance

and deductibles at point of service.³ Until the Health-Care Reform Act of 1988, the sickness funds even paid for taxis the elderly might take to see the doctor.

As a general rule, all West Germans have free choice of doctor, hospital, pharmacist and other providers of health care. Closed-panel arrangements—such as the American Preferred Provider Organization (PPOs) of Health Maintenance Organization (HMOs) that lock patients into defined subsets of providers—are unknown in West Germany, although there had been unsuccessful attempts to introduce HMOs in West Germany prior to World War II.

The comprehensive insurance coverage enjoyed by West Germans is provided by a highly structured and highly regulated insurance system that cannot be easily labelled as either private or public in the American sense of those terms. About 90 percent of the population is covered by the so-called Statutory Health Insurance system (the *Gesetzliche Krankenversicherung* or GKV) that has, for over one hundred years, constituted the backbone of the country's health-insurance system. Close to 9 percent of the population is covered by private, commercial insurance carriers. The remainder is covered by various governmental programs, notably those for the police and the military. The number of uninsured individuals at any point in time is below 0.3 percent.

Figure 3 provides a road-map of this structured health-insurance system. The percentages shown in that display represent the fraction of the West German population belonging to each type of insurance carrier.

The Statutory Health Insurance System (The GKV)

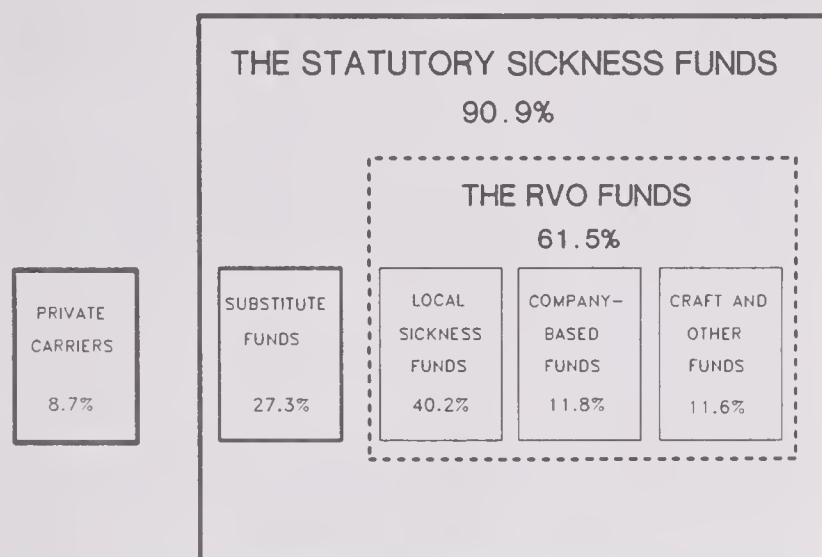
The Statutory Health Insurance System (the *Gesetzliche Krankenversicherung* or GKV) is composed of some 1,200 fiscally independent, self-governing, not-for-profit sickness funds, each of which serves either a specific, typically small geographic area (the Local Sickness Funds or *Allgemeine Ortskrankenkassen*), or the workers of a particular firm (the *Betriebskrankenkassen*), or members of a particular trade or craft (the *Innungskrankenkassen*). Together, these funds are commonly referred to as the "RVO" funds. They have been the corner stone of the country's social security system, which dates its

³ There are some co-payments for certain dental procedures and for some higher-priced brand-name drugs for which lower-priced substitutes are available.

origin to the late 1800s, and were originally intended to cover only blue-collar workers.

Figure 3 The Structure of the West German Health Insurance System

(THE NUMBER ARE PERCENTAGES OF THE POPULATION IN EACH TYPE OF FUND, 1986)



SOURCE: Verband der Privaten Krankenversicherungen e.V. Die Private Krankenversicherung, Zahlenbericht 1987/88, p. 13.

The operation of the RVO Funds (including benefit package as well as underwriting and reimbursement practices) have been tightly regulated by a federal insurance statute (the *Reichsversicherungsordnung* or RVO), which has been amended repeatedly to adapt the Statute to changing demographic and economic conditions.⁴

Subsequently, there were added to the RVO Funds the Substitute Funds (*Ersatzkassen*) for white-collar workers. There are now 15 such funds, each of them operating nationwide. The Substitute Funds, too, are subject to the federal insurance statute and form an integral part of the Statutory Health Insurance system (the GKV). Until very recently, blue-collar workers in the Statutory system did not have access to the Substitute Funds, which were reserved strictly for white-collar workers. The latter, on the other hand, could elect membership in either a Substitute Fund or the RVO fund relevant to their locality or company. Since the Health Reform Act (*Gesundheitsreformgesetz* or GRG) of 1989, however, blue-collar workers exceeding a certain income limit may elect membership in either their appropriate RVO Fund or a Substitute Fund or private health insurance. It can be expected that, before long, the archaic distinction between

blue- and white-collar workers will disappear altogether from the Statutory system.

Every West German is entitled to join the Statutory Health Insurance system. An individual's "membership" in a Statutory sickness fund automatically covers all of the member's dependent family members. Membership in the Statutory system *compulsory* for employees with a specified income limit (currently about DM 55,000 (\$30,000) per year) and for retired persons who had belonged to the system during their work life. At this time, roughly three quarters of the 90 percent of the population insured under the Statutory system are compulsory members. The remainder have joined the system voluntarily.

Once a West German joins a particular sickness fund within the Statutory system, he or she typically remains with that fund for life, unless his or her income rises above the threshold below which Statutory insurance is compulsory and the individual exercises the option either to join a Substitute Fund or to choose private health insurance.

Employed sickness-fund members pay for their own and their families' insurance coverage with a contribution that is strictly a percentage of their total compensation (roughly, salary and fringe benefits before taxes)⁵ and not at all related to either the size of the family or its health status. The premiums of retired persons are paid by the retirees' pension funds in the form of a flat percentage of the retiree's pension (now a national average of 12.9%). That percentage is equal to the average payroll contribution rate (the *Beitragssatz*) working members make to the fund.

Obviously, the premiums paid by the elderly are much below the true actuarial cost of caring for the elderly. In 1989, for example, the premiums paid by the elderly covered only about 40 percent of the sickness funds' outlays on the elderly (in 1977 that percentage had still been as high as 65 percent). The difference is made up by cross-subsidies paid by working members of the funds, a transfer that is becoming a source of contention among the generations. Funds with a particularly heavy load of retired members receive compensating contributions from a national reserve fund (the *Krankenversicherung der Rentner*). The objective of that system is to equalize across the various sickness funds the financial burden imposed by the aged on working members.

Because premiums in the Statutory system are based on ability to pay and cover also the insured

⁴ Incidentally, the RVO Statute has served as a model also for the Dutch and Belgium health insurance systems.

⁵ The system maintains the fiction that half of this contribution is paid by the employer and half by the employee. In fact, of course, the total contribution can be thought of as being paid out of the worker's gross wages.

member's dependent family members, while commercial carriers charge premiums based on actuarial cost, most individuals who do have the option to seek private coverage nevertheless prefer coverage under the Statutory system as well (although there has been somewhat more rapid migration to the private system in recent years). Furthermore, under the recently passed Health Insurance Reform Act of 1989 (the *Gesundheitsreformgesetz* or GRG), persons who have opted out of the Statutory system in favor of private health insurance lose the right ever to return to the Statutory system (as they hitherto could). Younger, single persons who may now find it financially advantageous to exit the Statutory system may later come to regret that step when they found families. They will therefore think twice before opting out of the system.

Administration of the Statutory System—The Statutory sickness funds are managed within the private sector, under the stewardship of boards of trustees, half of whose seats are filled from the ranks of unions and half from the ranks of employers, with the chairmanship rotating between these two groups.

In principle, each of these funds is to be fully financed by its members, who are either workers or retired persons. Since passage of the Health-Care Reform Act in 1988, however, sickness funds in particular fiscal distress do in some states receive cross-subsidies from financially better off funds.

Although the Statutory sickness funds tend to consider themselves part of West Germany's private sector, they are at best a distant cousin of what Americans would consider the "private sector." The Statutory funds operate within very tight Federal statutes that, as noted, dictate not only the catalogue of benefits these funds must offer their members, but also their governance, as well as their fiscal and regulatory relationships with the providers of health care. One may therefore think of the Statutory system also as a private-sector extension of the government's will. They are private, self-financing and self-governing entities charged with certain governmental duties and, therefore, endowed with certain governmental powers, among them the power to levy payroll taxes on employed persons and their employers and to redistribute economic privilege among its members.

Compensation of Providers Under the Statutory System—Within a region (usually a state or a sub-state region), the Statutory sickness funds join together in associations to negotiate with counter-part associations of physicians schedules of fees that must be accepted by the individual physician as payment in full. The *regional* negotiations are based on a

national relative-value scale (the *Einheitlicher Bewertungsmaßstab* or EBM) that is negotiated for the entire Statutory Health-Insurance System between *national* associations of all sickness funds and the corresponding national associations of sickness-fund physicians.

Although, as members of the Statutory Health Insurance system, the Substitute Funds (*Ersatzkassen*) share with the RVO Funds the common, *national* relative-value scale for physician services, they negotiate the monetary value per relative-value point separately with the corresponding *regional* physician associations and have traditionally paid slightly more than the RVO Funds. In 1988, for example, they paid physicians Deutsche Mark (DM) 0.0935 per point, versus an average of about DM 0.0915 per point paid by the RVO Funds. The RVO Funds in a region all pay the same fees to physicians. Americans would describe such an arrangement as an *all-payer system*.

In 1985, the sickness-fund physician associations agreed to accept an overall expenditure cap for their services. Although it had been hoped by the associations that this cap would eventually be lifted, the cap is still in place and is apt to remain so for the foreseeable future. Because all Statutory sickness funds work with the same relative value scale, it is easy to implement the cap under that system: if the utilization of services threatens to put total expenditures over the cap, the monetary value per relative-value point is automatically reduced.

The expenditure cap is negotiated annually as so many Deutsche Marks (DM) per insured, after adjustments for age and sex. Once that amount has been set, the total budget is turned over by the sickness funds to their counter-part physician associations who then disburse the fund to their members on a fee-for-service basis. In a nutshell, then, the system subjects all physicians to a zero-sum-game jealously watched by the physician associations themselves. It is they who police their own members.

The introduction of the expenditure cap for physicians has not led to the rationing of health care, a consequence widely predicted by the American Medical Association for the expenditure targets proposed for the United States. On the contrary, the steady decline of the monetary value per relative-value point in West Germany suggests that the number of services delivered to patients has **increased** substantially as a result of the cap.

The Statutory sickness funds negotiate jointly with *each* hospital a predetermined, binding per diem based on approved, projected line-item operating budgets.

As already noted, these per diems now average about \$ 180. There has been some experimentation with reimbursement by DRG on the American model, or with a system that combines a basic per diem with a fee-for-service catalogue for ancillary services.

Unlike the typical American health insurance policy, West German insurance policies typically provide fairly complete coverage also for dental care (including dentures) and for all prescription drugs.

Dentists are paid negotiated, predetermined fees for their services. These fees have been so high in recent years that West German dentists enjoy a higher income than do West German physicians in private, ambulatory practice (who earn a pre-tax net practice income of about \$ 90,000). In order to curb the disproportionate growth in their outlays for dental care, which appears to be driven by outlays for dentures, recent legislation has mandated substantial cost sharing by patients for dentures.

Until January of 1989, both the private insurance carriers and the Statutory sickness funds paid pharmacies the full retail price of whatever medications physician had prescribed. Patients did not share in the cost of prescriptions drugs, but merely paid a modest fee (DM 3) per prescription. The price the insurance carrier was forced to pay the pharmacist was the sum of (a) the manufacturer's price, *which the manufacturer was free to set plus* (b) a regulated, fixed wholesale mark-up plus (c) a regulated, fixed retail mark-up. The private carriers and the sickness funds all pay the same retail price.

This open-ended pricing policy left the demand-side of the market effectively without countervailing power. Combined with the effect of full-insurance coverage, it led to a relatively large allocation of West German health-care expenditures on prescription drugs. As is shown in Figure 2, close to 17 percent of total direct health-care expenditures in West Germany go for the payment of pharmaceuticals. In the United States, where over 75 percent of all drugs and sundries are still paid for directly by patients at point of receipt, only about 7 percent of total direct health-care expenditures goes for that item.

To control the large outlays for prescription drugs in the West German health system, the conservative Kohl government drastically altered the payment for insured prescription drugs as part of its so-called Health-Care Reform Act passed in November of 1988. For West Germany's pharmaceutical industry, this Act has been nothing short of revolutionary. It is bound to shrink the size of that industry in the years ahead.

Henceforth, prescription drugs are to be assembled into groups of "equivalent" drugs, where the definition of "equivalency" is to be broadened gradually over time eventually to include groupings of totally different chemical substances deemed to be "therapeutically equivalent" (Phase III in the evolving definition of "equivalency"). Under the new pricing policy established by the Act, the insurance carrier covers fully only the price of a selected low-cost drug in the equivalence group—typically a generic. If patients or their physicians insist on a higher-priced brand-name drug, the patient must pay the price differential out of pocket.

So far, the publication of the first equivalence groupings and the least-cost for each has completely shocked the pharmaceutical manufacturers and has led brand-name producers to slash their prices by up to 40–50 percent for competing drugs within the announced groupings. They have done so, because they fear that West Germany's spoiled patients will never consent to paying sizeable sums out of pocket for brand-name drugs in the equivalence groups.

The Commercial Insurance Carriers

The roughly 5.5 million West Germans (close to 9 percent of the population) covered by the 42 private, commercial (for-profit) insurance carriers in 1986 include civil servants, self-employed individuals, retirees who were covered by private insurance during their work years and white collar workers with an income above about DM 55,000 or \$ 30,000 per year (in 1989/90) who have chosen to opt out of the Statutory system.

As already noted, the premiums charged by the private carriers reflect the actuarial risk of five-year cohorts. Unlike the Statutory system, which employs coinsurance only sparingly, privately insured patients may choose among alternative plans, with varying degrees of cost-sharing and commensurately varying premiums.

An insured who enters an insurance contract with a private carrier pays the premium appropriate for his or her five-year cohort *at that time*. Thereafter, the premium is not raised further as a function of the insured's age. It can be increased only to reflect general increases in health-care costs that affect all age groups. In effect, then, this premium structure resembles the level-premiums American life-insurance companies levy for their whole-life life-insurance policies. And like these policies, a private West German health-insurance policy overcharges young people rel-

ative to their own actuarial, short-term risk and forces them to build up an old-age health-insurance reserve, the so-called *Altersruecklage*.

By law, West Germans who decide to leave their private insurance carrier for another private carrier forfeit their accumulated old-age health-insurance reserve. Furthermore, upon joining the other carrier, such persons must then pay the premiums appropriate for their age-cohort *at the time of the switch*. This policy is intended to force privately-insured persons into life-cycle planning as well, for it contains the powerful financial inducement to stay with one carrier for life.

About 4.6 million West Germans covered by the Statutory system purchase supplementary insurance coverage from the private carriers. These supplementary policies typically cover semi-private accommodations in hospitals and cash allowance per hospital day or day of illness.

The private insurance carriers compensate physicians on the basis of a statutory fee schedule (the so-called *Gebuehrenordnung fuer Aerzte* or GOA) set by the Federal government (after consultation with experts and the medical profession) and applicable only to the private-insurance sector. Although, in principle, the relative value scale underlying this fees schedule is not the same as that underlying the fee schedule used by the Statutory Health Insurance system (the so-called EBM schedule described earlier), the two relative value scales have come ever closer together over time, as the government leaned on the Statutory RVS in establishing the RVS for the private health-insurance system.

As a rule, physicians treating privately-insured patients may bill the insurer up to 2.3 times the official fee schedule, as most of them now do. Physicians may exceed even this maximum multiple, but only after justifying such extra billing in advance and in writing. Some physicians do so—notably the chiefs of staff in hospitals who, as a rule, may treat patients on a private basis very much like their American colleagues who have hospital privileges.

For hospital care, the private insurance carriers pay predetermined per-diems. These lie somewhat below the per-diems paid by the Statutory system, because hospital-based physicians who treat private patients in the hospital (typically only the chiefs of services) bill their patients directly for in-patient physician services, while the per diems paid hospitals by the Statutory sickness funds cover all in-patient physician services rendered by the hospital's staff of employed physicians.

In addition to this (somewhat lower) basic per diem, however, the private carrier must pay sizeable surcharges for the semi-private rooms (typically double-occupancy rooms) occupied by their insured. In 1988, for example, the average basic per diem rate for private insurers was DM 251 (\$ 128) and the surcharge for a private room was DM 116 (\$ 60).

The private carriers and the Statutory sickness funds pay the same prices for prescription drugs.

Administrative Cost of West German Insurance

The administrative cost of West German health-insurance is relatively low.

For the Statutory sickness funds, these costs amount to about 4 to 5 percent of total premium income. Although the sickness-fund physician associations who actually pay the individual physician have additional administrative cost, the overall administrative cost of the system, including the billing costs borne by individual physicians and hospitals, probably lies substantially below the average such leakage registered by the complex American system.

The private insurance carriers distinguish between purely administrative costs—about 4.4 percent of premium income in 1987 and probably comparable to the number reported by the Statutory sickness funds—and the so-called “closing costs” (*Abschlusskosten*), which represents the marketing and administrative costs of establishing new insurance policies. In 1987, these closing costs amounted to about 11.6 percent of total premium income.⁶ It appears, then, that the total loss ratio (payments to providers/premium income) in private health insurance exceeds that under the Statutory system by a considerable margin.

LESSONS FROM THE WEST GERMAN EXPERIENCE

The American health-care system, which relies on a great number of independent third-party payers for its financing, faces problems not encountered by systems, such as Canada's, in which the flow of funds to pro-

⁶ See Verband der Privaten Krankenversicherungen e.V., *Die Private Krankenversicherung: Zahlenbericht 1987/1988*, September 1988, p.54. According to that annual report, the pure administrative costs in 1987 were DM 602 million, said to be 4.33 percent of total premium income. The total closing costs for that year were reported as DM 1.6 billion, which must therefore have represented 11.6 percent of total premium income.

viders is concentrated in the hands of one single third party, usually the government.

First, in a multi-carrier system the providers may find it easy to divide payers and thus rule them. Second, if consumers are given free choice among competing insurance carriers, a multi-carrier system can be plagued by judicious, adverse-risk selection, and the exclusion of high-risk, low-income families from insurance coverage altogether. The American health system furnishes a prime example of all of these tendencies.

Both sets of problems have been addressed through statutory constraints in the West German health system, although not with complete success. Indeed, there are now sufficient stresses in the system to have triggered widespread calls for a fundamental reform of West Germany's health-insurance system.

Amassing Market Power on the Demand Side

The diagrams in Figure 4 overleaf depict two distinct set of relationships among the three major actors in health care: patients, providers and third-party payers.

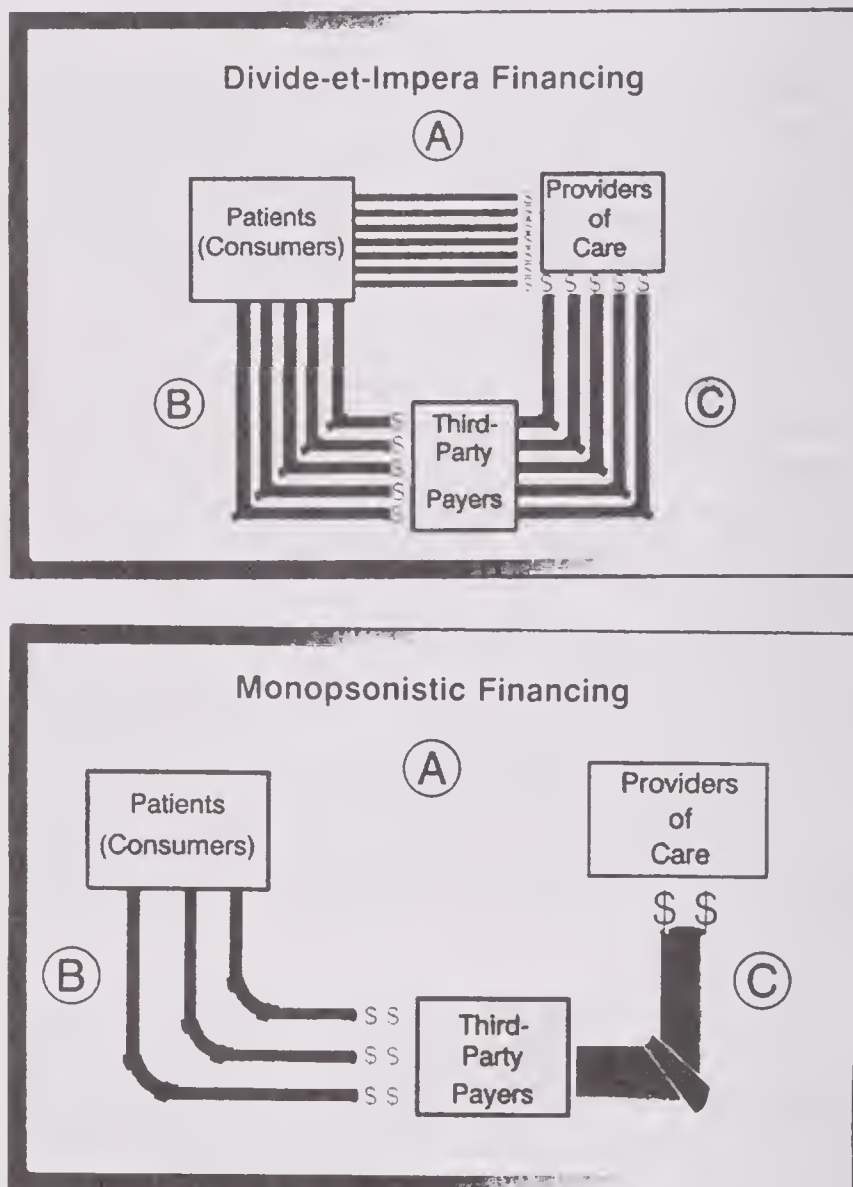
The top figure illustrates the manner in which money flows from society to the providers of health care. That flow now goes through a myriad of independent and uncoordinated pipes of varying size. Most of these pipes are so small, relative to the overall money flow, that persons controlling their valves cannot exert much influence over the market for health care. Should they seek to constrain prices, they can easily be threatened by providers with loss of access to health for the insured covered by that money pipe. It is a system designed to maximize the transfer of Gross National product from the rest of society to the providers of care.

Indeed, it is a system so constructed that it effectively shields most Americans from knowing, at any time of the year, precisely how much their families spend on health care. The money flow from households to pay for uninsured services, coinsurance for partially covered services, contributions to insurance coverage, and so on is so complex that it takes a special effort to tabulate it all for one year.

It can be argued that this is precisely as it should be, that most other markets in the economy also are characterized by a myriad of money pipes to the suppliers. The counter-argument that has prevailed in

most modern societies—certainly in West Germany—is that the ethical dimensions of health care, and the fact that the bulk of health expenditures are accounted for by very sick, aching and frightened individuals makes analogies with regular markets moot for health care.

Figure 4 Alternative Financial Arrangements Between Patients, Providers and Third-Party Payers



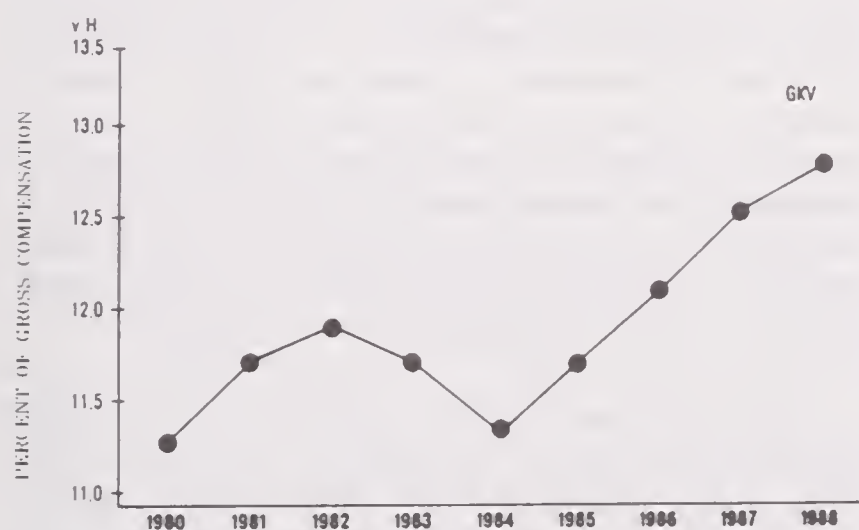
Most other countries have therefore all but relieved the individual patients from the role of a cost-controlling consumer. Instead of conceiving of the health-care market as a set of economic transactions between individual patients and providers, they have transferred the economic facet of these transactions to a middle plane where prices are negotiated between associations of third-party payers and association of physicians. In other words, they have concentrated the money flow to providers into one (or at most a few) large pipes whose valves are operated through negotiation, as is illustrated in the bottom panel of Figure 4.

In the Canadian health system, for example, there really is but one money pipe to providers per province. That pipe originates in the provincial government, which administers health insurance in that country. In West Germany, on the other hand, there are over a thousand pipes going from the sickness funds or private insurance carriers to the providers. The money flow through these pipes, however, is coordinated at the level of the state (*Land*) into all-payer systems which offers the payer a degree of market power similar to that enjoyed by truly single-source payers. For that reason, it is not inappropriate to think of West Germany's health system as effectively a single-pipe system as well.

Every German household knows what it spends per year for comprehensive health service, for that spending can be read off a simple barometer: the percentage of gross-compensation paid to the sickness fund, or the insurance premium paid to a private carrier. This simple index is very carefully read by the citizenry, by employers and by the government. Figure 5, taken directly from the trade journal of the Local Sickness Funds, illustrates this barometer graphically. The previously cited Health-Care Reform Act of 1988 was the government's reaction to the sharp increase in the contribution rate after 1984. The chief objective of that Act has been to stabilize that contribution rate.

Figure 5 Average Premium in the Statutory Health Insurance System

(PREMIUM AS PERCENT OF GROSS COMPENSATION)



SOURCE: AOK Bundesverband, "AOK Bilanz '88: GRG verstaerkte den Ausgabenwuchs," *DOK Politik, Praxis, Recht*, vol. 12, June 15, 1989, p. 367.

The single-pipe or quasi-single-pipe health-insurance systems prevalent throughout Europe and in Canada have certain advantages and drawbacks that deserve further comment.

First, the systems enable those who directly and ultimately pay for health care to procure health services at lower monetary transfers to provider per unit of real health service than is paid under the looser American system. Second, these systems enable those who control the valve of the single pipe literally to determine that physical capacity of the health system. They can make favorable turns of the valve contingent upon regional health planning, as is the case in all of these nations.

In short, then, the single-pipe approach probably more so than any other factor enables these countries to allocate to health care a much smaller slice of the Gross National Product than is being allocated in the United States. If Americans are unwilling to countenance that approach and prefer to continue with their myriad-pipe system, they are likely always to pay more for health care, per unit of service and overall, than they otherwise would.

But these single-pipe systems also have drawbacks that should be acknowledged.

Clearly, a single-pipe system is vulnerable to possible mistakes made by the few who wrangle at the single valve. Such a system may allocate less to health care than the citizenry actually would like to see allocated, if it had its choice, and it may also provide less variety in health care than the citizenry might want.

Furthermore, such a system makes it far more risky for entrepreneurs to venture their funds in search of new medical technology, because those at the valve may capriciously refuse to pay for that technology.

Finally, from the viewpoint of providers single-pipe systems are clearly undesirable. They manifestly tend to reduce the providers' income. There is no reason why normal, income-seeking providers of health care should favor a system that serves to shrink their income.

Avoiding Adverse-Risk Selection

The term "adverse-risk selection" has varied meanings in discussions on health policy, and it is often misused. For purposes of this discussion, adverse-risk selection refers to situations in which the distribution of actuarial risks among different insurance pools is not perfectly matched by the distribution of premium income needed to cover those risks.

Suppose, for example, that the likelihood of particular levels of health expenditures for an individual

could be accurately ascertained by both the individual and the insurer issuing that individual a health insurance policy. Suppose now that it were possible to group people into distinct cohorts so that all people within a cohort are exactly alike in their likelihood of incurring particular levels of health expenditures. There would thus be cohorts of relatively healthy people and cohorts of relatively sickly people. For a large enough cohort, one could then quite accurately predict the total health expenditure that would be incurred by that cohort for a given future period. On dividing that total by the number of persons in the cohort, one would obtain an average predicted expenditure level. In the jargon of insurance actuaries, and of economists, an insurance premium set equal to this average predicted level would be said to be an "actuarially fair" premium.¹ The premium would be considered "fair" in the sense that it would not force cohorts of relatively healthy persons to subsidize with their insurance premiums cohorts of relatively sickly persons, a cross-subsidy actuaries define as "unfair."²

An insurance industry that always charged perfectly actuarially fair premiums could be said to be free of adverse-risk selection, because a particular insurance pool's premium income would always fully reflect and cover its own mix of risk.

Two factors of the real world intrude upon the actuary's idyllic world.

First, the individual's likelihood of future health expenditures usually cannot be ascertained with such accuracy. And even if the individual could ascertain it, he or she would surely not reveal it to a prospective insurance carrier if that revelation would drive up the actuarially fair premium. From the insurer's perspective, the selective withholding of facts has always been considered fair game in this context. In this asymmetry of information—the fact that the buyer of insurance knows so much more about him or her health status than the prospective insurer ever will know—lies a major source of adverse risk selection.

Adverse risk selection, of course, can originate also on the insurer's side when insurers have some discretion in composing the risk-mix of their members in response to externally determined insurance premiums. It might occur, for example, when a government announced that it will pay a voucher of \$ X per member in some cohort—e.g., the Medicare cohort—and insurance carriers then seek to enroll in that predetermined premium only individuals whose

actuarially fair premium is below \$ X. From the insurer's perspective, such judicious risk picking is probably considered fair game as well.

Quite aside from the problem of adverse-risk selection, however, most of the world considers the actuary's conception of "fairness" ethically repugnant. This is the second intrusion of the real world on the actuary's idyllic model.

The dominant notion throughout Europe and in Canada is that health insurance should not only help smooth the individual's own outlays for health care over time, but that it should also force chronically healthy people to bear part of the health-care costs incurred by the chronically sick, and that the insurance mechanism is the ideal vehicle to effect this redistribution. This notion is fundamental to these countries' idea of community and neighborhood.³ As noted, they call it the Principle of Social Solidarity.

West Germany's Statutory Health Insurance system is a perfect expression of that principle. The system openly uses health-insurance premiums to redistribute income from healthy and high-income households to low income households and to the sick. To cope with the adverse-risk selection such a premium structure might otherwise engender, the system has traditionally limited the choice individuals and their families have among different sickness funds.

Traditionally, the freedom faced by compulsorily insured West Germans has been dictated by location and/or employment. Blue-collar workers among these typically have had a choice, if any, among only one or a few KVO Funds, although white-collar workers had a wider choice among KVO Funds and Selbstkassende Funds. Even the 25 percent or so of the population who are not compulsory members of the Statutory system, but may join that system voluntarily, have much less effective freedom of choice than is typically available in the United States. All Statutory health insurance funds, for example, must offer the same catalogue of prescribed benefits, and they cannot raise their premiums to the individual's actuarial risk.

Although private insurers do have greater freedom in that respect, their policies also are much more uniform in their premiums and much more restrictive than is typical in the free-wheeling United States health-insurance market. And, in strictly moral terms, these premiums are almost invariably too small to be

¹ Of course, in the "actuarially fair" premium there would be almost no allowance for administrative costs.

² In fact, only last year the American Council of Life Insurers declared such a cross-subsidy to unfair in a nationwide advertising campaign.

³ Economists and actuaries regularly counter this notion with the argument that the proper redistribution is not from the healthy to the sick, but from the wealthy healthy to sick in the poor area. Such an argument, they argue, can be effected through taxes and transfers, but not through private insurance premiums in the healthy area.

non-transferable old-age reserve that effectively locks an insured into a particular private carrier for life.

Threats to the Principle of Solidarity

Not surprisingly, this approach to eliminate adverse-risk selection and, at the same time, to effect a redistribution of income through the Statutory system's premium structure has led to considerable strain within the system. Because the individual sickness fund is empowered to levy whatever payroll-tax is necessary to cover the risk-mix of its own members, these taxes vary widely among the funds. Table 3 illustrates this phenomenon with the most recent data. It is impossible to defend these highly different payroll-tax rates with any appeal to social equity, and one must wonder why these differentials have not led to a more open revolt among the insured and their employers alike. But that revolt is starting.

Table 3 Variance in the Payroll-Tax Rate Across West German Sickness Funds, 1988

| Type of Fund | Payroll-Tax Rates * | |
|---------------------------|---------------------|---------|
| | Range | Average |
| Local Sickness Funds..... | 10.8–16.0% | 13.5% |
| Company-based Funds..... | 7.5–15.0% | 11.5% |
| Craft-based Funds..... | 9.8–15.6% | 12.8% |
| Substitute Funds: | | |
| —blue collar | 10.2–14.6% | 11.9% |
| —white collar | 18.8–12.9% | 12.7% |
| All Statutory Funds..... | 7.5–16.0% | 12.9% |

* Employer's and employees's contribution to sickness fund, as a percentage of gross compensation (including fringes).

SOURCE: Guntram Bauer and Franz Schoenhofen, "Risikostrukturen und Beitragsunterschiede in der GKV," *Die Ortskrankenkasse*, vol. 22, November 15, 1988, Table 1, p. 650.

Round One in that revolt is the increasing tendency among large business firms to take their employees out of high-premium sickness funds and to fold them instead into newly established company-based sickness funds (*Betriebskrankenkassen*) whose actuarial health-care costs may be lower. As Table 3 shows, such a switch might yield these companies substantial savings, at least in the short run, while their fund members are still young. Naturally, this move is vigorously opposed by the other funds in the system, particularly by the Local Sickness Funds that cover a demonstrably higher average morbidity.

The Local Sickness Funds have entered the fray from another corner. They would like to see legislation mandating inter-fund financial transfers to compensate for differences in the risk borne by individual

funds. Such transfers are already being made in some states within particular types of sickness funds (for example, within the company-based funds), but not yet across types of funds.

Although the Local Sickness Funds do have a legitimate point, their plea is opposed by other funds in the system on the ground that, pushed to its logical conclusion, the policy would convert the Statutory Health Insurance system into one single, national fund, a *Universalkasse* with one level of payroll tax and one benefit package for all members. Such a result, although perfectly equitable on its face, would make the Statutory system resemble more and more a fully government-financed system, such as Canada's.

Yet another attack on the present system comes from West Germany's neoclassical economists who, like their colleagues on this side of the Atlantic, regard as the only fair and efficient health-insurance system one priced strictly on actuarial principles and one offering every citizen the widest conceivable choice among competing funds. Neoclassical economists believe that governmental paternalism should not override individual myopia and that the individual should be made to suffer the consequences of his or her myopia. Neoclassical economists also believe that health insurance premiums are not a proper vehicle for the redistribution of income—that if society wishes to assist poor and sickly citizens, it should do so with taxes and cash transfers (or, at most, vouchers).

The West German government plans to arbitrate the emerging fight over West Germany's health insurance system with legislation scheduled for 1992. Considerable public debate will precede that legislation. If the philosophy of the Local Sickness Funds were to prevail, the West German health-insurance system would move substantially toward a government-financed system on the Canadian model. On the other hand, if the neoclassical school of thought were to prevail, the system would abandon the *Principle of Solidarity* altogether and become more like the American health system. The status quo is unlikely to be tenable over the long run.

West Germans, however, would be unlikely to move toward the American health-insurance model which is decried, throughout Europe, as not only wasteful, but also grossly inequitable. A move towards the Canadian model probably would be more palatable to West Germans unless, as seems more likely, the system can evolve towards a more workable middle ground. One such compromise might be a

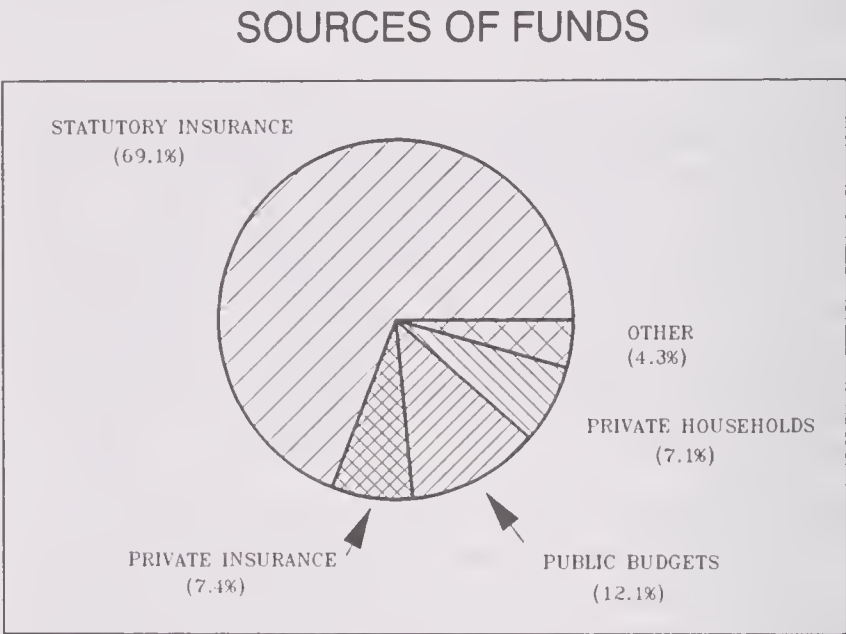
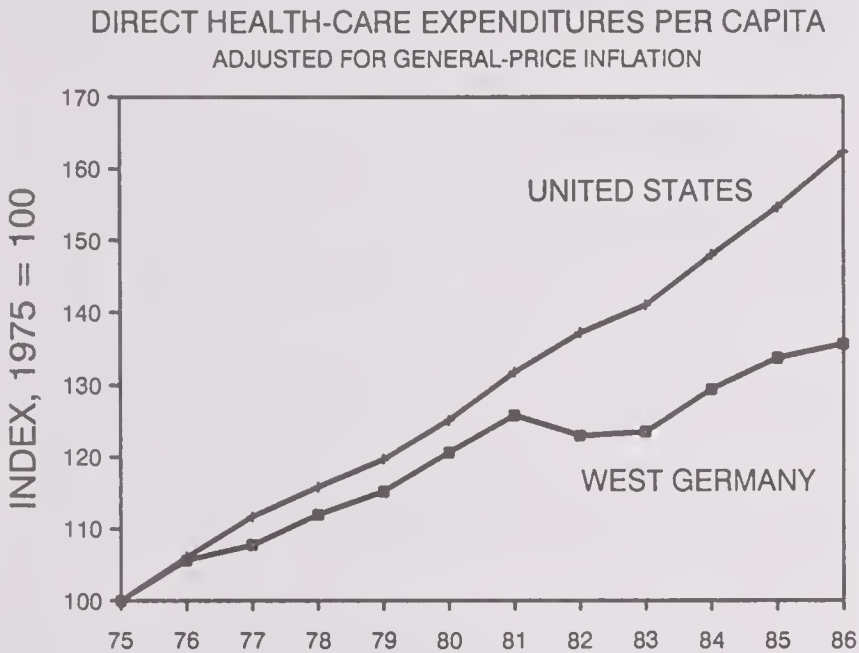
model akin to the highly regulated pluralism advocated by Enthoven and Kronick.¹⁰

An alternative compromise might be to mandate upon the system more extensive inter-fund redistributions of premium income and to encourage more extensive emigration from the Statutory system towards the private-health insurance sector. That approach would preserve the structured health-insurance system (*die gegliederte Krankenversicherung*) that, according to most West Germans, has served the country well for over a century.

A basic lesson Americans can draw from the West German health experience is that it is possible to provide universal access to health insurance—and to needed health care—without having the financing for such a system flow through the public budget.

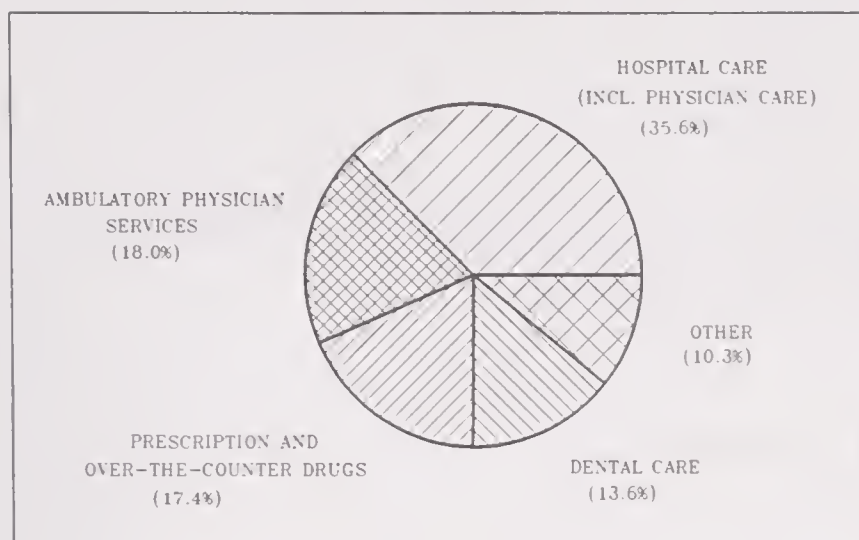
At the same time, the West German experience illustrates that it is extremely difficult, and probably impossible, to maintain an *unregulated*, pluralistic, *competitive* health-insurance system that avoids adverse-risk selection and, at the same time, maintains horizontal equity in the financing and distribution of health care.

The more freedom of choice is granted to those who purchase health insurance from a multitude of competing insurance carriers, the more opportunities there are for both the insured and the carriers to sort people into distinct risk classes, and the more inequitable will the distribution of health care and its financing, unless society were willing to subsidize the health-insurance premiums of high-risk, low-income persons with tax-financed subsidies.

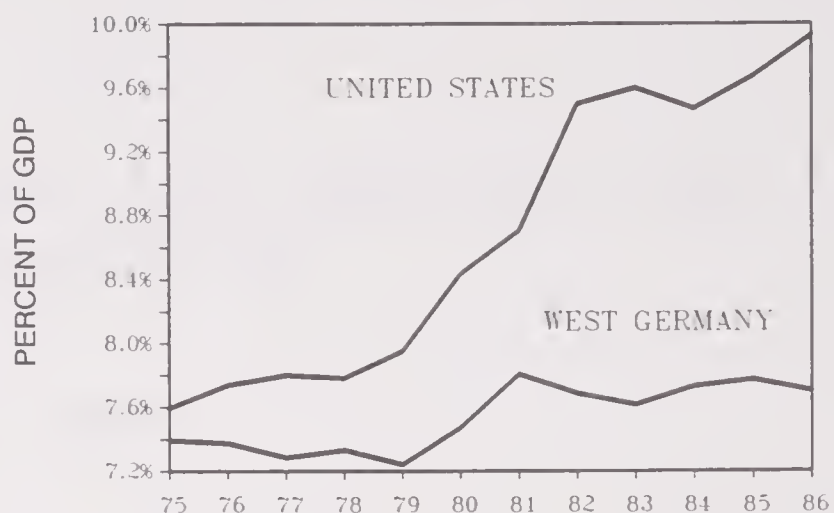


¹⁰ Alain Enthoven and Richard Kronick, "A Consumer-Choice Health Plan for the 1990s," *The New England Journal of Medicine*, Vol. 320, January 5, 1989, pp. 29-37 and vol. 320, January 12, 1989, pp. 94-101.

USES OF FUNDS



DIRECT HEALTH-CARE EXPENDITURES, 1975-86 AS A PERCENT OF GROSS DOMESTIC PRODUCT



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EUROPE'S DECENTRALIZED AND SEMI-PRIVATE HEALTH INSURANCE

William A. Glaser *

OVERVIEW

Several European countries have the health insurance arrangements most relevant for reform in the United States. Their characteristics are:

- Administration of finance by private health insurance carriers. These are mutual aid societies or mutual insurance companies. Some have existed for centuries and antedate obligatory health insurance laws. They jealously guard their independence from government.
- These carriers compete for members and for prestige.
- Many citizens—all, in some countries—have freedom of choice among carriers.
- Some citizens—many, in some countries—are free to self-insure completely.
- Government's role is limited. It does not dictate. A law of Parliament specifies the minimum benefits for subscribers. Parliament levies payroll taxes on employers and workers, since health insurance is part of the social security system. Government may subsidize the health insurance accounts from general revenue. Several Ministries set guidelines to contain costs within the fiscal capacity of the system.
- Mechanisms exist to stabilize costs.
- The working rules and fees of doctors are negotiated between the medical association and the health insurance carriers. These matters are never imposed on doctors unilaterally by government.
- All big decisions are made through elaborate negotiations and through compromise. The governments themselves are ruled by coalition Cabinets, whose political parties differ in preferences about social insurance and about health care finance.

Germany

Like the United States and Switzerland, it has a federal system of government. General frameworks are enacted by the national Parliament and by the national Ministries, but the health insurance carriers and providers are organized distinctly in each province, producing diversity in levels of finance and in some administrative implementation.

When first enacted a century ago, the law required certain occupational groups to join health insurance funds, it levied payroll taxes on the workers and their employers, and it listed benefits that the carriers must provide. Additional occupations were added to obligatory coverage in successive amendments to the law. The payroll taxes suffice to cover both the worker and his/her family. But obligatory coverage never became universal: one-fifth of the population over an earnings threshold can opt out completely.

Once Germany had thousands of health insurance carriers of varying sizes. Most were for workers in individual factories. Some enlisted all craftsmen (such as the butchers) in a city. Others enlisted all members of an industry (such as seamen) throughout the country. In each area there has been a general fund for anyone whose occupation does not assign him automatically to one of the occupationally based carriers. Besides all these, there are "substitute" funds for persons over an earnings threshold but not yet at the level where they are exempt from obligatory coverage. The number of carriers has greatly diminished, primarily because of bankruptcies and mergers among the workplace funds.

Besides these social funds that receive and use payroll taxes, Germany has private insurance companies. If someone's income exceeds the membership ceiling, he is exempt from the social insurance coverage but

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may buy his health insurance from these commercial carriers voluntarily.

The Netherlands

Until reforms scheduled for the early 1990's, Holland never had universal obligatory coverage. All persons below an earnings ceiling were required to join a social insurance carrier, financed by payroll taxes and government subsidies. Everyone above that ceiling had to seek private commercial insurance. The pensioners could choose either sector, usually were priced out of the private policies, and usually rejoined the social insurance carriers. After 1990, everyone will be covered by obligatory statutory health insurance.

In the past, Holland had hundreds of small local social insurance funds. Some were created by doctors, some by trade unions, some by employers, others by Catholic associations. Any subscriber could choose any carrier. The social insurance funds steadily merged, and now usually there is only one in each locality. All the separate federation offices have united into one national office that represents all carriers.

In addition, there are several dozen nationwide mutual insurance companies that once specialized in selling policies to the persons over the earnings ceiling. In the 1990's, when the entire population is covered by statutory health insurance, the commercial carriers will serve this market too. Therefore, social insurance will again have competing carriers.

Switzerland

The country has never enacted nationwide obligatory health insurance. A few cantons require coverage by persons under an earnings ceiling, but that is all. Therefore, most of the population can opt out and self-insure.

Once Switzerland had over one thousand health insurance carriers, but mergers have reduced the numbers to less than four hundred. They are nonprofit mutual insurance companies or mutual aid societies. Some are nationwide, others are regional. Anyone can choose any carrier.

Because health insurance is not part of the national government's social security system, the carrier's revenue does not consist of percentage-of-earnings payroll taxes. Each individual subscriber pays a monthly premium calculated by age and sex at time of first

enrollment. There are no family policies. Because employers contribute no payroll taxes, the national government makes up the shortfall by contributing grants from general revenue. The subsidies vary by the number, age, and sex of each carrier's subscribers. As a condition for receiving the grants, the carrier must follow rules about minimum benefits and maximum patient cost-sharing. The grants induce nearly every citizen to join, and they standardize the policies of the carriers. Through private and voluntary methods, Switzerland achieves the same results as those in countries with obligatory health insurance.

Once the elderly, the very poor, and the unemployed were not covered by statutory or by voluntary health insurance. They were aided by municipal welfare offices—i.e., the European counterpart of Medicaid—or they became bad debts in public hospitals. But now in all three countries, all the elderly, poor, and unemployed are obligatory enrollees in social insurance funds. The voluntary market consists of upper income people who can fend for themselves.

Patterns of coverage in 1985—shortly before Holland adopted universal statutory coverage—were:

| Basic acute-care coverage | West Germany | Holland | Switzerland |
|----------------------------------|--------------|---------|-------------|
| Social insurance funds: | | | |
| Obligatory by law | 79% | 51% | 25% |
| Voluntary | 12 | 19 | 71 |
| Private insurance companies..... | 7 | 30 | 2 |
| Not insured | 2 | 0.1 | 2 |
| | 100% | 100% | 100% |
| (Total population in millions) | (61) | (14) | (6.4) |

CHOICE AND COMPETITION

Any widespread statutory program inevitably has many standard features. Minimum benefits are universal. The payroll tax rate is usually (not always) identical for all carriers and all subscribers. Often patient cost-sharing rules and provider balance-billing rules are universal. Since carriers use tax money and (often) public subsidies, all must accept certain rules of financial management. Usually carriers under tax-supported social insurance must be nonprofit.

Among Social Insurance Carriers

Nevertheless, the obligatory subscriber in all three of the countries can choose among the carriers for his

basic statutory coverage. And the carriers can compete for the largest numbers of the most desirable subscribers.

Where they have a choice, subscribers prefer social insurance carriers with the following characteristics:

- More benefits without asking for higher payroll taxes (in countries with variable payroll taxes, like Germany); without asking for supplementary premiums (in countries with fixed payroll taxes, like Holland); and without asking for higher premiums (in countries with a variable premium system, like Switzerland).
- Better services for patients, such as responsive information staffs, health publications, and fast processing of claims.
- Attractive public image.

A social insurance carrier in such a competitive market seeks subscribers who will yield financial surpluses: higher incomes and higher payroll tax yields in countries with payroll taxes (like Germany and Holland); and lower morbidity. They try to attract such desirable subscribers by various appeals:

- More benefits without charging higher premiums: higher allowances for private hospital rooms; more generous dental coverage; lower cost-sharing (for dentistry, drugs, etc.) if this is allowed under the law; inducing better service by doctors by offering higher fees (a method used only by the “substitute” carriers *Ersatzkassen* in Germany because of a loophole in the system of negotiating fees).
- Lower payroll taxes and premiums in countries where the rates are flexible (Germany and Switzerland). It is rarely done to attract subscribers in the social insurance market, since the carriers prefer to offer better benefits.
- Image and prestige. Used by the *Ersatzkassen* of Germany to attract the white-collar workers and managers who otherwise could choose the workplace or regional carriers traditionally identified with labor. In the past in Holland and in Belgium today, some mutual assistance funds are associated with the Catholic Church and the Socialist Party, and they appeal to Catholics and socialists.
- Better services for subscribers are a very common marketing method.

While subscriber choice and carrier competition exist in the social insurance market, all-out competition is limited for several reasons. (In contrast, greater competition is possible in the private health insurance market, to be described in later paragraphs.)

- The law guarantees certain benefits for all persons. While competing carriers can add benefits, they cannot reduce them, they cannot offer policies with lower premiums for fewer benefits. Usually the law prevents them from offering policies with lower premiums in return for higher patient cost-sharing.
- Social insurance carriers need to earn money over the actuarial costs of the workers paying payroll taxes and premiums. They are obligated to accept pensioners, the poor, and the unemployed whose payments to the carrier are much lower than their costs. Therefore, social insurance financing must be redistributive. The carriers cannot compete for subscribers by price-cutting that lowers revenue.
- Some features of administration and finance lock the subscriber into one carrier and inhibit free choice and carrier competition. For example, Swiss social insurance carriers charge age-of-entry lifetime premiums that increase as the subscriber ages. Level premiums cover lifetime actuarial costs by overcharging the subscriber while he is young and undercharging him while he is old. Carriers compete by offering different rates for the same age of entry. If a subscriber wishes to change carriers, he joins the new one at the starting rate for his current age, which probably exceeds the rate he currently pays his original carrier. Consequently, he usually hesitates to change. The Swiss social insurance market therefore has much less competition and fewer transfers than one might expect. The lifetime premium system has the important advantage of protecting persons from prohibitive increases in old age.

Competing social insurance carriers would prefer to avoid attracting subscribers who will cause deficits: persons with lower incomes and lower payments (such as the pensioners and the poor); and persons with higher morbidity. However, in practice the carriers can only woo the better risks, not screen out the less healthy persons. These are social security programs designed to protect the vulnerable by redistributive financing, and the carriers are expected to fulfill their duties. They cannot reject any applicant under social insurance, no matter how poor a risk, and they can do no medical underwriting of rates. The carriers take the long view: they woo young subscribers who yield financial surpluses, they use marketing appeals to keep these subscribers during their productive work years, and they cover these subscribers' high costs in old age. The strategy assumes a steady recruitment of young new subscribers. If the carrier's portfolio ages—as in the case of funds with blue collar workers in declining industries in Ger-

many now and in Holland in the past—the carriers can go bankrupt.

Between Social Insurance Carriers and Private Insurance Companies

Over an earnings ceiling in Germany today and in Holland until the 1990's, certain classes of subscribers have had to buy statutory health insurance but may buy it from either the social funds or the private companies. Under either arrangement, the subscriber and his employer pay the standard payroll taxes.

As in the aforementioned choices among social insurance funds, the subscriber prefers a carrier that offers more benefits, better services, and an attractive public image. In addition, this category of persons prefers carriers that charge lower premiums, even if the benefit package is thinner. These people are younger, healthier, less at risk, and reluctant to pay extra cash to cover the costs of the worst risks.

The private carriers appeal to this group by offering lower payroll taxes (or premiums) and/or better benefits. They select preferred risks and have fewer expensive subscribers than the social insurance funds do.

This competition and the preferred risk selection arouse protests by the social insurance carriers and by the political Left: the social carriers are left with the elderly and other bad risks, and they run deficits; the private carriers do not share the burden of a supposedly universal social program; the taxpayer should not be forced to rescue the social insurance funds with subsidies, while the private carriers waste money, say the critics. Whether reforms take place depends—like many other health policies—on the political decisions of the government-of-the-day:

- The Center-Right Cabinet in The Netherlands during the 1980's amended the health insurance law and required the private health insurance carriers to keep their members after retirement. These companies can no longer force the elderly to transfer back to the overburdened and subsidized social insurance carriers, by charging them very high age-related premiums.
- In order to avoid punitive actions, the association of private health insurance funds in Holland has given the association of social insurance carriers several lump sums to cover the bad risks and elderly subscribers that the private carriers avoid recruiting and once avoided keeping.
- All the Dutch political parties agreed to amend the law in the late 1980's, making statutory health

insurance universal. Holland therefore ceases to be the last European country with a large unregulated private market, with benefits and premiums selected by the subscribers according to their own self-interest. Every Dutch citizen is now covered by payroll taxes, every social insurance fund and all private companies become carriers for basic benefits, every citizen has free choice of carrier, preferred risk selection by a carrier is banned, and the extra cash collected from the better paid persons covers the extra costs of the elderly and of the bad risks.

- None of these remedial measures have been adopted in Germany. Healthier risks steadily and voluntarily move to the "substitute" funds (*Ersatzkassen*) from the workplace funds (*Betriebskrankenkassen*) and from the regional funds (*Ortskrankenkassen*). As a result, many workplace funds run deficits and close; and the regional funds must charge higher payroll taxes and offer lower benefits than the substitute funds do. Legislative reform is blocked by the fact that the political party allied with the substitute funds (the Free Democratic Party) has been part of every coalition government in the national and most provincial governments for twenty years.

Among Private Insurance Companies

In these arrangements, one type of private market sells basic coverage to the upper income persons exempt from obligatory insurance, as in Germany today and in Holland until the 1990's. (Such a separate private market for basic coverage does not exist in Switzerland, since all Swiss get basic benefits—obligatorily or voluntarily—from the mainstream carriers who receive grants from government.) Another type of private market sells voluntary supplementary policies for those benefits not provided by statutory social insurance. It exists in all European countries, will survive in The Netherlands, is targeted at all persons, covers many people in some countries (such as France), but is purchased only by the wealthy in most countries.

Both of these private markets are very competitive, and subscribers do considerable shopping. Since these markets are not part of social insurance financed by payroll taxes and public subsidies, the subscriber pays his own cash. He may get a voluntary subsidy from his employer, but private employer group insurance—common in the United States and in private insurance in Great Britain—is rare in Europe. Subscribers prefer private policies with the following characteristics:

- Lower premiums. Since they are affluent, they can afford higher cost-sharing (in return for lower premiums) and can afford to self-insure for routine services (such as general practice and pharmaceuticals).
- Adequate coverage of big risks.
- Coverage of specialists' fees. The patient is then guaranteed personal attention from the chief of service when he is hospitalized. Social insurance covers hospitalization in general and care by the entire medical staff.
- Some new benefits attract subscribers, such as dentistry and long-term care.

The private insurance companies compete with the following offers:

- Lower premiums, particularly aimed at the young. Bursts of competitive price-cutting occur, preventing established private insurers from community rating and eliminating extra cash to cover the elderly redistributively.
- A great variety of options, particularly policies with schedules of lower premiums for greater patient cost-sharing.
- Limited policies that omit general practice.
- Development of policies and literature making each company's offers appear unique and hindering consumers' comparisons among companies.
- Some benefits exceeding those of other companies, such as more generous coverage of physicians' fees.
- Occasionally individual companies offer completely new policies, such as coverage of long-term care. However, others quickly follow. Because regulatory bodies discourage undue insurance risk that will ruin the company and strand subscribers, the association of private insurance firms may design new packages for the entire industry. The companies then compete over variants and over price.

COMMUNITY BEARING OF RISKS

Every European statutory health insurance arrangement is part of the larger social security system, and the entire package is permeated by the vocabulary and spirit of "social solidarity." None of these countries are "socialist" in government or in economies: private enterprise, the pursuit of individual gain, and wide variations in income characterize their societies.

But health care financing differs and is designed to protect the vulnerable through redistribution:

- The poor, disabled, and elderly are guaranteed mainstream coverage under insurance. Public charity has been phased out.
- The healthy and wealthy pay into the social insurance funds payroll taxes or premiums higher than their actuarial costs, to provide extra cash for the bad risks.
- Governments use general tax revenue—based on progressive income and business taxes—to subsidize the social insurance carriers.
- In a few countries (such as France, Belgium, and Holland), the health insurance carriers with extra cash transfer some insurance revenue to the carriers with deficits.
- Price-cutting competition that would enable the rich and healthy to keep their cash and that would underfund the system is reduced by law or by regulation.

The trend is toward making the social insurance system a single pool. Any person (no matter how old or how unhealthy) can pick any carrier. No social insurance fund can reject an applicant, can charge an extra risk-related premium, or can force out a long-time subscriber after retirement. Each carrier is expected to raise enough cash to cover the bad as well as the good risks; only after that can it cut premiums or add extra benefits as competitive tactics to attract the healthier, richer, and more profitable subscribers. If a carrier faces deficits because of its portfolio, it is merged or subsidized. Party politics (and, ultimately, the configuration of interest groups) determines the timetable: this trend was achieved long ago in some countries with statutory health insurance (such as France and Belgium), is being implemented only now in Holland, and still has not yet been fully adopted as public policy in Germany.

COST CONTAINMENT

Government can announce and enforce levels of costs where its general budget pays all providers—such as in Great Britain, Sweden, and Canada. But it cannot dictate total spending so easily in countries with statutory health insurance, since the carriers are autonomous, the providers are private, every subscriber is guaranteed access to all benefits without waiting, and doctors have complete authority to decide patients' needs and to prescribe care.

For many years, countries with statutory health insurance let patient demand, doctors' judgments, and provider prices determine costs. Payroll taxes were steadily increased, the earnings ceilings for the payroll taxes were eliminated in a few countries (France and

Belgium), and governments added subsidies to cover the deficits resulting from full coverage of the elderly and unemployed. Costs had to be controlled, since the payroll taxes became burdensome and governments had to curb their subsidies. But government had limited power over health insurance, carriers, and providers. Therefore, an elaborate system of negotiation among government Ministries, payers and providers has evolved to set and implement expenditure targets. Procedures differ among these countries, but all have multi-centered negotiations.

Setting Expenditure Targets

An “expenditure target” is a voluntary agreement among payers, providers and government to try to hold health care spending at a specified level for a specified time. A target may refer to all health care, health care traditionally covered by third parties, or a specific health care service (such as physicians, hospitals, pharmaceuticals, or laboratory tests).

An expenditure target states fiscal or budgetary goals that providers and payers voluntarily try to achieve. Expenditure targets are frequently agreed upon in order to obviate the need for government controls. An “expenditure cap,” on the other hand, is a fixed amount of money allocated to a particular sector or to individual providers by government or by insurance carriers.

Expenditure targets are used to contain costs in European statutory health insurance. Expenditure caps are used in systems entirely financed by government, as in Canada, Great Britain, and Scandinavia. One of the few uses of fixed caps under health insurance is the payment of doctors in Germany from time to time, to be mentioned below.

The setting of expenditure targets—like everything else in European health insurance—results from negotiations among all the interested factions:

- In Holland, Belgium, France, and many Swiss cantons, the guidelines are negotiated among the Ministries of Social Affairs, Health, Budget, and Finance. Each Ministry is influenced by various interest groups in the population and by different factions in the governing coalition: Social Affairs (which usually directs the social security system) speaks for the trade unions, the health insurance carriers, and the left wings of the political parties in the governing coalition; Health speaks for providers (particularly hospitals), the workers in health, and patients; Budget must balance the demands from all Ministries, from all existing

government programs, and from the governing coalition’s new proposals; Budget must minimize public subsidies to health insurance; Finance tries to avoid raising payroll and other taxes; Finance in practice represents business interests in expenditure and social policies. Each Ministry develops its case for higher or lower health spending with the help of its own statisticians. Once viewpoints diverged and Prime Ministers often had to mediate. But now everyone agrees that increases in payroll taxes and public subsidies should be avoided, all the Ministries agree on basic facts (particularly the expected yield of the payroll taxes next year), and all the Ministries agree on this expenditure target.

- In Germany, a standing forum represents all the interest groups, viz., the associations for doctors, hospitals, dentists, and pharmaceuticals; the business associations; the trade unions; the health insurance carriers; and others. It meets at least once a year and is called the *Konzertierte Aktion im Gesundheitswesens*. A staff from the Ministry of Labor provides data, particularly about the expected yield of payroll taxes. A committee of neutral experts—chiefly university professors—prepares options papers and special reports. The forum negotiates annual expenditure targets in all health sectors, usually within the expected fiscal capacity of the payroll taxes.

Hospitals

Payment under statutory health insurance in all countries uses all-payer rates. Since every hospital has its unique costs, it has its own rates, calculated to provide enough revenue to cover its budget, approved prospectively by the following methods:

- Germany’s model of private negotiations is extended to the determination of its hospital rates. Every German hospital seeking reimbursement under statutory health insurance must fill out a retrospective cost report and a prospective budget every year, covering the hospital’s entire business. The required information is specified in a law of Parliament. The forms are written by the staff of the Ministry of Labor, after consultation with the national association of hospitals and the national associations of health insurance carriers. Each hospital (backed up by its provincial hospital association) submits its proposed prospective budget for next year to a joint bargaining committee of the local health insurance carriers. They argue over the hospital’s performance and needs. Usually they compromise over a daily rate that will cover the

hospital's costs next year and that binds all the carriers. In case of deadlocks, the hospital and carriers create an arbitration committee, which usually awards an increase pursuant to the expenditure target recommended by the *Konzertierte Aktion*.

- In most countries with statutory health insurance (such as Holland, Switzerland, France, and Belgium), the hospital's rates are set by investigators employed by government. They are impartial experts respected by all; they are essential because of the complexity of the subject and because they alone can compel production of the hospital's books in order to verify the hospital's statements of its financial needs. The regulator analyzes the hospital's prospective budget pursuant to detailed guidelines and expenditure targets sent down by the national Ministries. The local health insurance carriers also receive the hospital's prospective budget and retrospective cost reports, and they provide advice about the efficiency and quality of the hospital's past work, the hospital's need for its entire request. The hospital can appeal denials to the higher ranks of the regulatory commission (in Holland) or the higher ranks of the Ministry (in France, Switzerland, and Belgium).

Expensive high-tech programs can no longer proliferate around the country, fueling cost explosions. In most countries with statutory health insurance, government plays an important role by providing capital grants for new buildings and advanced new technology. Particularly in their early stages, governments try to limit the expensive programs to major centers with expert clinical staffs and high utilization. Duplication and low utilization are avoided. The rate regulators will not allow the social insurance carriers to pay the operating costs of unapproved programs.

Holland is one of the very few countries which (like the United States) allows its hospitals to borrow in the capital market, buy whatever they want, and amortize the capital costs in their operating budgets. Once the rate regulators were permissive. Now they are tightening approval of the operating and capital costs for high-tech.

Because government has limited power under statutory health insurance, because the hospitals are private or municipal, and because the hospitals have much political influence (usually in the political parties of the Center), hospital facilities planning is often weak. It is difficult to force hospitals to reduce beds or to close.

Doctors

The guidelines about costs are implemented as follows:

- Fees and other rules of practice under statutory health insurance are always negotiated every year between the medical associations and a joint bargaining committee from the associations of health insurance carriers. Because of the wording of the law and the need to win the cooperation of the doctors, government never dictates the physicians' pay. Most countries settle doctors' pay at the national level, but the Swiss negotiations occur in each canton. The fee schedules and other agreements apply to all payers except for the small market for private insurance and private out-of-pockets. Because rising utilization and service intensity have increased their medical services costs, the health insurance carriers now grant only small increases in fees. The carriers invoke the expenditure targets and argue that trends in utilization and service intensity threaten them with deficits. The annual negotiations over fees are often disputatious, but the medical associations usually settle, because they know that the sickness funds cannot grant more money than the probable fiscal yield of the payroll taxes, and because doctors' earnings rise as utilization and service intensity grow, even when the fees themselves (i.e., the "conversion factors") rise little. The medical associations can demand arbitration by government but usually don't: they will lose an appeal nowadays, since their incomes rise substantially from utilization and service intensity even when their fees rise little, and since all political parties (even the conservatives) and the government's finance officers expect such an affluent occupation to accept restraint.

Balance billing is illegal under statutory health insurance in some countries (such as Holland and Switzerland). It is allowed in a few countries under the social insurance contracts (such as France and Belgium). But it is infrequent: doctors usually extra-bill only the wealthier patients.

- Utilization and service intensity are difficult to limit. Doctors have full authority under the laws of medical practice and social insurance to prescribe whatever they think the patient needs, and the health insurance carriers are obligated to pay. Health insurance carriers collect the claims data, create statistical profiles, identify some deviants who seem to file too many claims, and employ control doctors to caution the overbillers. But these methods have been hesitant and ineffective. Health insurance carriers and medical associa-

tions in some countries (such as France and Belgium) now try to implement effective utilization review as part of the joint negotiating machinery.

In Germany, the health insurance associations turn over both the money and the utilization review task completely to the medical association. The German method—used at times of strict cost containment—represents the only fixed expenditure cap over physicians' reimbursement under statutory health insurance, but it is administered completely by the doctors themselves. Under this system, the doctor is not guaranteed the same fee throughout the year. If utilization and service intensity rise faster than expected so that the account faces deficits, the managers reduce the fees for new claims. In countries with targets rather than caps, the insurance carriers pay all claims in full, reallocate or borrow to cover the excess over the expenditure target, and limit more strictly their concessions to the doctors in next year's negotiations.

Pharmaceutical Drugs

Governments play a larger role, since the health insurance carriers cannot cope by themselves with such a powerful and complicated industry. Although a smaller proportion of total health care costs than hospital and physician spending, drugs grow too.

- All governments license drugs to ensure safety. Some regulate prices for all citizens.
- Most countries with statutory health insurance have formularies limiting the number of drugs to be reimbursed under the programs.
- All countries require patients to pay some of the drug costs under social insurance, to discourage over-prescription and waste.
- Utilization is difficult to control, since all doctors have the right to prescribe what they think best, the newest drugs are very expensive, and the carriers are obligated to pay. At best, various regulations and financial incentives try to persuade doctors, pharmacists, and patients to prefer the less expensive generic substitute.

CONTROLLING HEALTH CARE COSTS

Mark Merlis *

ABSTRACT

Concerns about rapid growth in U.S. medical expenditures have led to a variety of proposals for controlling health care costs. This report reviews current health care cost control proposals, including both regulatory and competitive options. The report provides an overview of the concepts underlying these basic approaches and the evidence available about their ability to achieve savings and their potential impact on access and quality of care.

SUMMARY

Inflation in the medical sector has outpaced inflation in the rest of the economy for many years. There are concerns that continued growth in health care costs could impede efforts to improve access to health care and could eventually erode the access that already exists. While efforts to control medical spending have been a central issue in health policy at least since the early 1970s, these concerns have given the issue a new urgency.

Most proposals to limit health care spending have relied on one of four basic approaches. The first is to change the behavior of consumers by holding them directly responsible for a larger portion of the costs of their own care. Increases in required deductible and coinsurance payments by enrollees in health plans can reduce overall costs. However, they may have a disproportionate impact on low-income persons, deterring even necessary care, and may not affect the treatment decisions of providers, who control much of total health spending.

The second major approach is to change provider behavior through direct modification of medical prac-

tice, or by controlling the overall supply of medical resources. Insurers have had some success in controlling inpatient hospital services through external review systems, but savings have been largely offset by a growth in outpatient services. These have proved harder to manage, in part because there is little agreement about what constitutes appropriate care. There are hopes that further research on the effectiveness of medical treatments can provide a basis for limiting unnecessary care. If reductions in utilization are to achieve their full savings potential, however, they may need to be accompanied by controls on the overall supply of medical resources. Supply controls through local health planning systems were attempted in the 1970s, but encountered political barriers and had limited success.

The third cost control approach is to change provider behavior through reimbursement systems that provide incentives for greater efficiency. Several States, as well as Canada and other nations, have adopted payment systems that fix in advance the resources a provider can consume in treating an individual patient or an entire patient population. These systems may encourage more cost-effective treatment, but may also delay the introduction of new medical technologies or otherwise compromise quality. Their long-term potential for cost savings may rest on the willingness of the public to accept trade-offs between cost and other priorities.

The last major approach is to encourage consumers to choose from among multiple health plans that compete on the basis of their ability to develop structured and efficient delivery systems. Health maintenance organizations (HMOs) and other managed care systems have shown some ability to control costs, using utilization controls, financial incentives for providers, and other methods. The ability of these programs to achieve their full savings potential may be limited by the reluctance of higher-cost patients to accept the restrictions on choice of providers imposed by HMOs.

* Report prepared by Mark Merlis, Specialist in Social Legislation, Education and Public Welfare Division, Congressional Research Service, January 26, 1990.

INTRODUCTION

The United States spends more per capita, and a greater proportion of its gross domestic product (GDP), on medical care than any other industrialized nation. U.S. health expenditures in 1987 reached \$500 billion, 11.1 percent of GDP, as compared to 8.6 percent in Canada, 6.8 percent in Japan, and 6.1 percent in the United Kingdom.¹ Despite its higher expenditures, the United States performs no better than other industrialized nations, and worse than many, on such measures of health care outcomes as life expectancy or infant mortality rates. These international comparisons have led many observers to conclude that our medical care system is much less efficient than those elsewhere, spending more for less.

Not everyone would agree. Gross measures of health status may reflect, not the relative efficiency of our medical care system, but other differences between the United States and other countries. Life expectancy, for example, may be tied to diet or environment, while infant mortality rates may in part reflect such factors as the rate of teenage pregnancy. Other aspects of quality may not be captured by these measures at all. For example, Americans (or at least insured Americans) may have greater access to advances in medical technology than persons in other countries or may be less likely to have to wait for non-emergency treatment. Assessing the efficiency of the American system depends in part on how one defines quality, a problem that will be considered further at the end of this report.

Whatever the relative quality of American medical care, there are concerns about the rate at which health expenditures are increasing. Inflation in the medical sector has outpaced inflation in the rest of the economy for many years. National health expenditures rose an average of 13 percent a year from 1970 through 1981. The rate of growth declined over the next several years, chiefly because of a decline in inpatient hospital admissions. Between 1984 and 1985 total costs rose just 7.9 percent, the lowest annual rate of increase since the enactment of Medicare and Medicaid in 1965 (though still greater than the growth in GDP). This moderation in expenditure growth proved short-lived. Costs rose 9.8 percent in 1987, and employers and insurers have reported dramatic cost increases over the next 2 years. For example, one recent survey has found that employers' average cost per employee for health benefits rose 19 percent in 1988.²

The return of double-digit medical care inflation after a temporary respite has led to concerns that continued growth in medical care costs could impede efforts to improve access to health care and could eventually erode the access that already exists. Many employers have already reduced their contribution to employees' insurance expenses, while the costs of public insurance programs are consuming an increasing share of State and Federal budgets. Proposals to extend coverage to the uninsured have raised concerns that any expansion of the insured population might lend a further impetus to medical care inflation, as did the enactment of Medicare and Medicaid in 1965. While the issue of health care costs and ways of controlling them has been a central one in health policy at least since the early 1970s, these recent developments have given the issue a new urgency.

This report examines policy options for controlling the increase in health care costs by modifying the way medical care is delivered or financed. Most proposals have relied on one of four basic approaches:

- Changing the behavior of consumers by holding them directly responsible for a larger portion of the costs of their own care;
- Changing provider behavior through direct modification of medical practice, or by controlling the overall supply of medical resources;
- Changing provider behavior through reimbursement systems that provide incentives for greater efficiency;
- Changing the behavior of both providers and consumers by encouraging consumers to choose from among multiple health plans that compete on the basis of their ability to develop structured and efficient delivery systems.

The remainder of this report provides an overview of the concepts underlying these basic approaches and the evidence available about their ability to achieve savings and their potential impact on access and quality of care. The greatest attention is devoted to the last of the four strategies, competition, because this approach has dominated policy discussion in recent years.

The report does not consider changes outside the health care delivery system that could directly or indirectly affect medical care expenditures. For example, the incidence of illness or injury might be reduced through public health or health education measures, stronger environmental controls, or improved safety regulation. Changes in the civil litigation system (i.e., malpractice reform) could reduce the practice of "defensive medicine" that is alleged to

¹ George J. Schieber and Jean-Pierre Poulhier, "International Health Care Expenditure Trends: 1987," *Health Affairs* 8 (3) (Fall 1989): 169-177 (Hereafter cited as International Health Care Expenditure Trends, 1987).

² Jerry Geisel, "Health Benefit Tab Rises 19% to New High," *Business Insurance* (December 11, 1989): 1.

result in the performance of unnecessary tests or procedures. Such measures might well play an important role in any comprehensive initiative to control medical care spending. They are omitted in order to allow this report to focus more directly on the medical care system itself and on proposals to change the way consumers and providers behave within that system.

Cost Sharing

Proposals to hold consumers responsible for more of the costs of their own medical care begin with the premise that comprehensive insurance coverage, largely funded by employers or government, has distorted the health care market by freeing consumers of any need to consider the utility or price of the services they are consuming. While not all observers share the view that growth in health care costs is driven by consumer choices, there are increasing calls for measures to encourage consumers to become more conscious of the price and utility of the medical services they use.

There are two broad ways of doing so. The first is to require consumers to pay a higher share of the premiums for their health care coverage, thus giving them an incentive to choose the most efficiently operated plan. This approach is the subject of the final section of this memorandum. The second method, considered in this section, is to make consumers pay more of the direct costs of the services they use by increasing the deductibles or coinsurance payments required under their insurance plans.

Increases in enrollee cost-sharing responsibility can reduce overall medical expenditures only if they deter some enrollees from obtaining care. Otherwise, they merely shift expenses from the insurer to the consumer.³ The major study of the impact of cost-sharing on health care utilization and costs was the Health Insurance Experiment (HIE) conducted between 1974 and 1982 by the RAND Corporation, under contract to the Health Care Financing Administration. The HIE randomly assigned 7,700 enrollees to a variety of health insurance plans, including a plan that included no cost-sharing (the "free" plan) and plans requiring coinsurance payments ranging from 25 to 95 percent (subject to overall limits on out-of-pocket expenditures).

³ Deductibles have other behavioral effects that may also produce cost savings. Enrollees whose costs during a year exceed the deductible by only a small margin may not go to the trouble of filing a claim. Other enrollees who are careless in record-keeping may be unable to document all of their out-of-pocket expenditures and may therefore spend more than the nominal deductible before the insurance takes over.

The key findings of the HIE were these: ⁴

- Cost-sharing reduced the probability that individuals would seek care for any particular medical condition. The strongest deterrent effects occurred among the poor, especially poor children. They were at least 40 percent less likely to obtain care for a given condition than children in the free plan.
- Cost-sharing deterred enrollees from obtaining both "appropriate" and "inappropriate" medical care. Low-income enrollees in the cost-sharing plans were less likely to seek care for conditions for which medical care is highly effective, as well as for conditions for which medical care is rarely effective. Those in the cost-sharing plans had worse outcomes for specific conditions (such as hypertension) that can be improved by medical treatment.
- While cost-sharing prevented enrollees from initiating an episode of medical care, it did not change the course of treatment once an individual had entered the medical care system. Within any given episode of care, the cost-sharing enrollees received the same services and medications as other patients.

These findings raise several important concerns about the utility of cost-sharing as an approach for reducing medical expenditures. First, as would be expected, its impact is greatest on enrollees with the least income. This effect might be modified by developing cost-sharing requirements that varied by income. Such a system might be administratively cumbersome for employers or insurers. It might also defeat its own purpose, since cost-sharing may not reduce utilization unless it is financially burdensome. (The HIE enrollees in the least burdensome cost-sharing plan actually incurred slightly higher costs than those in the free plan.)

Second, cost-sharing may deter necessary as well as unnecessary care. The goal of making consumers more prudent in their use of health services may demand a degree of sophistication about the value of different services that not all enrollees possess. There have been attempts to develop more carefully targeted cost-sharing systems, to control only inappropriate utilization or to channel utilization in particular ways. For example, a higher coinsurance amount may be imposed for emergency room visits, in order to

⁴ This summary is drawn from Kathleen Lohr, et al., "Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis and Service-Specific Analyses in a Randomized Controlled Trial," *Medical Care* 24 (9) (Supplement) (September 1986): S74-S77; and Robert H. Brook, et al., "Does Free Care Improve Adults' Health?: Results From a Randomized Controlled Trial," *New England Journal of Medicine* 309 (23) (December 8, 1983): 1426-1434.

prevent enrollees from using the emergency room for non-urgent care; this approach is common in health maintenance organizations (HMOs) and has been adopted by some State Medicaid plans. It is not certain, however, that even such narrower measures will deter only unnecessary care.

Finally, and perhaps most important from the perspective of cost reduction, cost-sharing may not modify the course of care once treatment has begun, presumably because the decision-making has generally shifted from the patient to the physician. This finding of the HIE is partly a result of the design of the experiment. Regardless of the level of cost-sharing required, each plan had an out-of-pocket limit, a point beyond which the insurer assumed full responsibility for all further expenses. In the absence of such a limit, enrollees might have been more likely to decline the services ordered by their physicians. At the same time, however, the most severely ill would have been subject to catastrophic financial losses.

Most medical care costs are incurred by a small minority of patients.⁵ A cost-sharing system without catastrophic limits will leave that minority unprotected, while a system with limits on out-of-pocket expenses may have a minimal effect on the total costs of care once treatment has been initiated. The problem of controlling the costs of ongoing treatment is the subject of the next section.

Changing Medical Practice

Because most medical care purchasing decisions are made by physicians and other providers, rather than by the patients themselves, savings might be achieved if unnecessary services could be eliminated through external review of those decisions or through efforts to modify the providers' own decision-making.

External Utilization Controls—The term “utilization controls” embraces a variety of external constraints imposed by a payer on the volume or nature of services furnished or ordered by providers.⁶ These include:

- Pre-admission certification for elective inpatient stays;

- Concurrent review, under which patients already admitted to the hospital are monitored to ensure the appropriateness of their continued stay;
- Voluntary or mandatory second opinions before elective surgery;
- Case management, under which the payer or the payer's agent attempts to assume control of the overall delivery of services to an individual high-cost patient;
- Various approaches for shifting the locus of care from high-cost to low-cost settings. These include requirements that certain surgical procedures be performed on an outpatient basis, or that diagnostic tests ordinarily required for inpatients be conducted before the patient is admitted to the hospital.

Utilization controls, especially pre-admission certification and concurrent review, have become a standard feature of health insurance plans during the 1980s. They are now used in the Medicare program, in 29 State Medicaid programs (as of 1987), and in 72 percent of employer-sponsored health plans (as of 1988), up from 59 percent just a year earlier.⁷ Despite the rapid adoption of utilization control systems by both public and private payers, they have received little systematic study, and evidence that they actually reduce spending is limited. Pre-admission review has the strongest track record; one controlled study found that it produced net savings for an average employee group of 7.3 percent, with even higher savings for groups that had very high utilization before the programs were initiated.⁸ The evidence on some of the other approaches is less clear. For example, some studies have suggested that voluntary second surgical opinion programs may not deter enough unnecessary surgery to offset the costs of the second opinions themselves; mandatory programs appear to be more successful.⁹

There are also concerns that even the most successful utilization control approaches focus only on inpatient care and may merely shift the site in which care is delivered without fundamentally changing medical practice.¹⁰ If a reduction in inpatient admissions is

⁵ In 1978, 10 percent of U.S. families accounted for 67 percent of total health expenditures. U.S. Congress, Congressional Budget Office, *Catastrophic Medical Expenses: Patterns in the Non-Elderly, Non-Poor Population* (Washington, D.C.: Government Printing Office, December 1982), xviii.

⁶ These techniques are sometimes referred to by health insurers as “managed care.” Others restrict the term “managed care” to the more aggressive interventions in the health care system represented by HMOs or similar entities. This is the sense in which the term will be used later in this report.

⁷ Phoebe A. Lindsey, “Medicaid Utilization Control Programs: Results of a 1987 Study,” *Health Care Financing Review* 10 (4) (Summer 1989): 79–92; and Jon Gabel, et al., “Employer-Sponsored Health Insurance in America,” *Health Affairs* 8 (2) (Summer 1989): 116–128.

⁸ Paul Feldstein, Thomas Wickizer, and John Wheeler, “Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures,” *New England Journal of Medicine* 318 (20) (May 19, 1988): 1310–1314.

⁹ For a review of the literature, see Danny Ermann, “Hospital Utilization Review: Past Experience, Future Directions,” *Journal of Health Politics, Policy and Law* 13 (4) (Winter 1988): 683–704.

¹⁰ For a discussion of this issue, see Institute of Medicine, *Controlling Costs and Changing Patient Care? The Role of Utilization Management* (Washington, D.C.: 1989).

followed by an increase in outpatient services, savings may be only temporary; soon costs may begin to rise again as rapidly as before. One observer has argued that, because technologies that were once available only in hospitals are now widely diffused in the community, the hospital is no longer the appropriate focus of cost-containment efforts. At the same time, however, utilization controls for ambulatory services have been slow to develop. In part, this is because most ambulatory services have relatively small prices. The administrative costs of reviewing each service may outweigh any potential savings.¹¹ Some insurers have begun to require prior authorization for the most costly outpatient services, such as CAT scans or other major diagnostic procedures. Whether such measures are actually producing savings is not yet known.

Utilization controls face another barrier that may be even more important than administrative costs: the subjective nature of medical practice. Each patient is somehow unique, and external reviewers may have difficulty overriding the clinical judgments of individual practitioners in specific cases. This may be especially true when there is little consensus about the most appropriate treatment for a given condition, a problem to be discussed in the next section. In any event, some observers have contended that a persistent physician who is prepared to appeal a denial of authorization will often prevail. (The relative leverage of the individual practitioner may have been enhanced by recent legal decisions subjecting external utilization control agents to malpractice liability for denials of necessary care.) In consequence, utilization review may function as a delaying tactic rather than an absolute control, achieving savings only because some physicians will not take the trouble to protest the reviewers' decisions. The result has been termed "rationing by inconvenience."¹² Such savings as are achieved may diminish over time as physicians become more skillful in dealing with the system.

For this reason, some analysts have suggested that savings over a longer term may depend on the extent to which providers "sign on" to the concept of eliminating unnecessary services. In this view, real utilization control will require voluntary changes in the way physicians practice medicine.

Modifying Practice Styles—Beginning in the 1970s, studies by Wennberg and others showed that there was substantial geographic variation in the rate of use of specific medical or surgical procedures. For example, the rate of tonsillectomies in one area of New

England was six times higher than the lowest rate in the region.¹³ While some of the variations uncovered in "small area analysis" might be attributable to differences in the incidence of illness in different populations, this explanation appeared to be insufficient to account for all the variation; some other factors had to be at work. One hypothesis was that physicians in different areas had different "practice styles." Each community had its own medical culture, its own characteristic way of diagnosing or treating particular diseases or conditions. Physicians adopted the practice style of their community in the absence of firm and objective information about which treatment approach was actually superior.

Other explanations have been offered for small area variations in medical practice; these will be discussed further below. However, the practice style hypothesis has won many supporters and has led to proposals for controlling medical care costs by (a) improving knowledge of the relative efficacy of different medical treatments and (b) disseminating this knowledge to practitioners in the expectation that they will modify their practice styles accordingly. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) establishes a new program within the Department of Health and Human Services for research on the effectiveness of medical treatments and the development of practice guidelines. Not all of the proponents of this initiative view it as a cost-containment measure. Some view it chiefly as a possible way of improving quality of care, and therefore worth pursuing whether or not any cost savings result. The following discussion, however, considers only the potential of medical practice research to reduce costs.

To have a significant impact, guidelines will need to address areas of practice on which there is real disagreement among physicians. There have been some efforts in the past to codify elements of medical practice on which there already existed a consensus. However, if most physicians already agree on the best treatments, promulgating that agreement in the form of guidelines may not have a measurable impact on medical practice. (This appears to have been the case, for example, with a 1984 consensus report on the treatment of high blood pressure.¹⁴) For this reason, the treatment research initiative will focus on conditions for which there is found to be a wide variation in current practice. Because the Nation is just beginning to devote significant resources to research on the outcomes of alternative medical treatments, it may

¹¹ Jeff C. Goldsmith, "Competition's Impact: A Report from the Front," *Health Affairs* 7 (3) (Summer 1988): 162-173.

¹² Gerald W. Grumet, "Health Care Rationing Through Inconvenience: The Third Party's Secret Weapon," *New England Journal of Medicine* 321 (9) (August 31, 1989): 607-611.

¹³ John Wennberg and Alan Gittelsohn, "Variations in Medical Care Among Small Areas," *Scientific American* 246 (April 1982): 120-134.

¹⁴ Martha N. Hill, David M. Levine, and Paul K. Whelton, "Awareness, Use, and Impact of the 1984 Joint National Committee Consensus Report on High Blood Pressure," *American Journal of Public Health* 78 (9) (September 1988): 1190-1194.

take time for researchers to reach agreement in cases where practice variation is the result of real scientific uncertainty. The full potential savings from this strategy might therefore be realized only over the long term.

Assuming that future research can resolve disagreements over appropriate treatments, there would remain the task of inducing physicians to modify their practices voluntarily on the basis of the new findings. Some success in changing practices has been reported when physicians have been introduced to guidelines through structured face-to-face educational programs conducted by respected peers.¹⁵ Some other efforts that relied only on printed materials to communicate practice recommendations have had disappointing results. Providers could be aware of and even approve the recommendations without making significant changes in practice. It is possible that some physicians may encounter barriers in implementing even guidelines with which they nominally agree. These may include concerns about malpractice liability, lack of the substitute skills or the special equipment needed to follow the guidelines, economic incentives, or pressure from patients.¹⁶ These barriers might be overcome with more vigorous educational efforts. Still, countervailing economic and professional pressures may limit the willingness or ability of physicians to comply voluntarily with treatment guidelines.

One alternative is to use the results of outcomes research as the basis for mandatory, rather than voluntary, guidelines—that is, as a way of strengthening or broadening current utilization control programs. Proposals to do so have met strong opposition from the medical community, on the grounds that medicine cannot be reduced to a “cookbook” and that to compel physicians to comply with fixed practice rules would stifle innovation. In addition, there would remain the problem of achieving sufficient savings to offset the administrative costs of review systems.

Another option is to replace service-by-service utilization review with general comparisons of each physician’s practice patterns to those of his or her peers. Physicians who, over time, consistently furnished or ordered more of certain services than others in the peer group would be targeted for closer scrutiny, to determine whether patterns of inappropriate utilization existed. Physicians found to be outliers might be the focus of special educational efforts in the hopes of

inducing voluntary change. Continued noncompliance might trigger requirements that individual services receive prior authorization or could even lead to exclusion from participation in a given public or private insurance program.

How much could be saved if all inappropriate services were eliminated? Some studies have found very high rates of unnecessary care. For example, Chassin et al., in a thirteen-site study, found that 17 percent of all coronary angiographies were unnecessary; for other procedures, the rate of inappropriate use was as high as 32 percent. They also found, however, that the unnecessary care explained only a small fraction of variations in utilization across geographic areas. If none of the inappropriate angiographies had been performed, the area with the highest use of this procedure would still have had more than twice the number of angiographies as the lowest-use area. The authors suggest that other factors must play a part in this difference: disease incidence, differences in the point at which primary care physicians decide to refer patients to specialists, or cultural or social differences in the stage at which patients sought care.¹⁷ Another multi-site study has found that, while practice style may explain differences in utilization of certain specific procedures, it does not explain overall differences in per capita use of medical care in different areas. At the aggregate level, standard socioeconomic factors could explain much of the difference in use and intensity of services.¹⁸

These preliminary studies suggest that there could be underutilization of services in some areas, while there is overutilization of the same services in other areas. Treatment research could pinpoint, not only cases in which unnecessary services could be eliminated, but also cases in which patients have had insufficient access (whether physical or financial) to necessary care. It is for this reason that some proponents of outcomes research have emphasized its potential impact on quality, rather than its potential for cost savings. Precisely because there is uncertainty about the relative efficacy of many treatments, it may be too early to say whether optimal medical treatment would involve more or fewer services than are currently furnished.

¹⁵ See Mark R. Chassin, “Standards of Care in Medicine,” *Inquiry* 25 (4) (Winter 1988): 437–453.

¹⁶ Jonathan Lomas, et al., “Do Practice Guidelines Guide Practice? The Effect of a Consensus Statement on the Practice of Physicians,” *New England Journal of Medicine* 321 (19) (November 9, 1989): 1306–1311; and Jacqueline Kosecoff, et al., “Effects of the National Institutes of Health Consensus Development Program on Physician Practice,” *Journal of the American Medical Association* 258 (19) (November 20, 1987): 2708–2713.

¹⁷ Mark R. Chassin, et al., “Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?” *Journal of the American Medical Association* 258 (18) (November 13, 1987): 2533–2537.

¹⁸ Sherman Folland and Milan Stano, “Sources of Small Area Variations in the Use of Medical Care,” *Journal of Health Economics* 8 (1) (March 1989): 85–107.

Supply Controls

If utilization controls or practice guidelines succeed in limiting unnecessary care, the full potential savings from any reduction in the number of services delivered may be realized only if there is a proportionate reduction in the resources used to provide those services. For example, changes in medical practice in the late 1970s and early 1980s led to a decline in inpatient hospital admissions without a corresponding reduction in hospital capacity. The result in many areas has been underutilized facilities spreading their fixed costs across a declining number of patients; while there are fewer patients, the cost for each patient rises because the unused capacity must still be paid for.

In addition, the existence of excess capacity may generate continuing pressures to find some new way of using that capacity and restoring utilization to its previous levels.¹⁹ The view that the use of medical services could rise to fill any underused resources led to what was perhaps the dominant approach to cost containment in the 1970s: health planning, the regulation of facility construction and other capital expenditures.

In 1964, New York became the first State to establish a certificate-of-need (CON) program, under which proposals to build a new facility or expand an existing one had to be approved by a government agency. Other States followed, and a 1972 amendment to the Social Security Act provided that facilities in those States proceeding with construction without obtaining a CON could be denied Medicare and Medicaid reimbursement for their capital expenditures. Finally, the Health Planning and Resources Development Act in 1974 required all States to establish similar programs. This requirement was repealed in 1986, along with all Federal support for State health planning programs. States may continue to operate programs on their own; 39 States and the District of Columbia still do so. However, Medicare reimbursement is no longer contingent on State approval of capital expenditures, and a number of States have now limited their reviews to nursing home construction.²⁰

Several factors contributed to the reversal of policy on health planning. In part, it fell victim to the gen-

eral preference for market as opposed to regulatory solutions during the early 1980s. From a Federal perspective, the adoption in 1983 of Medicare's prospective payment system (PPS) for inpatient hospital services was expected to offer a different way of limiting health care resources; this approach is discussed further in the next section.²¹ Underlying this shift, however, were claims that health planning had been tried and had failed, largely because of conflicting political pressures. In many areas, the oversupply of facilities was such that savings would have required, not just limits on new construction, but closure or consolidation of existing facilities. Few States were able to overcome the political resistance to such closures. Attempts to limit duplication of services or the spread of new technologies often faced similar barriers; attempts to plan for the rational distribution of resources on a regional basis had to confront providers' fears of losing to competitors and individual communities' desires for the most up-to-date facilities.²²

CON programs did have some successes, particularly in constraining the growth in nursing home beds. Because State Medicaid programs are the major source of payment for nursing home care, States had a strong motive to overcome the political barriers to supply constraint. In at least some States, the CON process was explicitly seen as a Medicaid cost-containment measure; the determination of the number of nursing home beds needed was related to the maximum number of patients the State was prepared to cover.²³ Even in this case, however, any savings were achieved by holding growth in bed supply below the rate of growth in the aged population. States generally did not close down existing capacity.

Recent concern about the rate of medical care cost increases has led to some calls for a revival of health planning, and it is conceivable that these concerns might eventually be sufficient to overcome the political barriers faced by health planners in the past. However, not all of the problems with health planning are political ones. Effective planning may require a fuller understanding of the workings of the health care system than is currently available. That system is a dynamic one, and decisions that seemed sensible in the late 1970s have sometimes had unpredictable effects. For example, most planning programs focused

¹⁹ The view that hospital admissions rise in proportion to hospital bed capacity was originally advanced by Milton Roemer, in "Bed Supply and Hospital Utilization: A Natural Experiment," *Hospitals* 35 (21) (November 1, 1961): 36-42; Some more recent studies have concluded that the relation between supply and utilization may not be as straightforward as "Roemer's law" would suggest. W. Ross Brewer and Mary Anne Freedman, "Causes and Implications of Variation in Hospital Utilization," *Journal of Public Health Policy* 3 (4) (December 1982): 445-454.

²⁰ American Hospital Association, State Issues Forum, *State Health Planning Report* (Chicago: July 1989).

²¹ The inclusion of capital expenditures in PPS payments has been repeatedly postponed. Hospitals are instead paid for Medicare capital expenses on a reasonable cost basis, subject to a fixed percentage discount (15 percent beginning January 1, 1990).

²² For an overview of the barriers to health planning, see Lawrence D. Brown, "Common Sense Meets Implementation: Certificate-of-Need Regulation in the States," *Journal of Health Politics, Policy and Law* 8 (3) (Fall 1983): 480-494. (Hereafter cited as *Common Sense Meets Implementation*.)

²³ Judith Feder and William Scanlon, "Regulating the Bed Supply in Nursing Homes," *Milbank Quarterly* 58 (1) (1980): 54-88.

on institutional services in hospitals and nursing homes, because these were the major sources of expenditure, and did little to control the capital expenditures of community-based physicians or clinics. The resulting growth in the availability of high-technology facilities outside hospitals is one of the reasons that recent reductions in inpatient utilization have been offset by increased outpatient costs. (Some States are now applying uniform rules across settings.)

Moreover, a community's needs may change unpredictably. New York was more successful than most States in controlling inpatient bed supply; it was one of the few States in which hospital closures occurred on a planned basis. While the number of community hospital beds nationally dropped 1.1 percent between 1977 and 1987, the number in New York dropped 9.9 percent.²⁴ New demands on these facilities in the 1980s, such as the appearance of AIDS (acquired immune deficiency syndrome) and the rise in drug-related problems, have led to serious overcrowding in some New York hospitals. The reported crisis in New York illustrates one of the potential constraints on the planning process. On the one hand, it may be necessary to maintain enough excess capacity to meet unforeseen needs or random fluctuations in demand. On the other hand, this excess capacity is costly to maintain and may itself generate demand. If the supply of a given kind of service is sufficient that no one ever has to stand in line for it, then the savings from health planning may be limited.

The fullest potential savings from health planning would require a more controversial step: limiting the supply of health resources to the point at which patients may have to wait for some period to obtain needed but non-emergency services. The result is "queueing," the delays in surgery or high-cost diagnostic procedures that are alleged to occur to some extent in Canada and to a greater extent in the United Kingdom. The degree to which queueing actually occurs in either country's health system has often been debated by those who favor or oppose adoption of a similar system here. Some people say that essential care may be unavailable, while others argue that resource limits merely oblige providers to set priorities and avoid unnecessary services.

Whatever the extent to which resources have been limited elsewhere, rationing of supply in the United States might raise concerns that are not as significant in countries where the entire population participates in a single insurance program. In those countries, everyone is in the same queue, and one's place in line is chiefly determined by the urgency or duration of

one's need. (There are exceptions: one can step out of line in the United Kingdom by finding a private provider, and there are anecdotal accounts that some Canadians with sufficient resources may seek care in the United States.) When queueing has occurred in the United States, however, places in line may have been determined by financial resources.

The facilities in New York reporting the greatest overcrowding have been those serving the poor and the uninsured. Similar effects may have resulted from health planning's major success, the control of nursing home bed supply. Because Medicaid payment is generally less than that available from private patients, nursing homes in areas with limited bed supply and high occupancy rates have an incentive to accept a private-pay patient when a vacancy occurs, while Medicaid beneficiaries may be unable to find a place. In 28 States, Medicaid administrators report that beneficiaries awaiting hospital discharge had difficulty finding a nursing home bed.²⁵ While supply constraints are not the only factors limiting access to care for low-income Americans, they may exacerbate existing problems. The acceptability of health planning as a cost control strategy may, then, depend in part on the extent to which supply limitations are accompanied by efforts to make distribution of limited resources more equitable.

One other issue should be raised in the context of a discussion of health resources: the debate over the possible oversupply of physicians and the potential consequences of physician supply on health care costs. In 1980, the Graduate Medical Education National Advisory Committee (GMENAC) reported that the United States would have a surplus of 150,000 physicians by the year 2000.²⁶ The extent of the potential surplus has since been the subject of continuing debate. There are questions about the extent to which technology and the aging of the population could increase demand, or the adoption of utilization controls or managed care could decrease it. The number of medical school admissions could decline, or physicians might spend more of their time on administrative activities and less on patient care.²⁷

²⁵ For a fuller discussion of this problem, see U.S. Library of Congress, Congressional Research Service, *Medicaid Source Book: Background Data and Analysis*. Report prepared for the House Committee on Energy and Commerce (Committee print 100-AA) (Washington, D.C.: November 1988), 467-483. (Hereafter cited as Congressional Research Service, *Medicaid Source Book*.)

²⁶ Graduate Medical Education National Advisory Committee, *Report to the Secretary, U.S. Department of Health and Human Services* (Washington, D.C.: 1980).

²⁷ For contrasting views on these issues, see William B. Schwartz, Frank A. Sloan, and Daniel N. Mendelson, "Why There Will Be Little or No Physician Surplus between Now and the Year 2000," *New England Journal of Medicine* 318 (14) (April 7, 1988): 892-897; Ernest P. Schloss, "Beyond GMENAC—Another Physician Shortage from 2010 to 2030?" *New England Journal of Medicine* 318 (14) (April 7, 1988): 920-922.

²⁴ American Hospital Association, *Hospital Statistics*, 1978 and 1988 editions.

Even less clear than the extent of the future surplus is its possible effect on medical costs. Observations that per capita use of physician services increases in geographic areas with a high ratio of physicians to population have led to the hypothesis of "physician-induced demand." Just as excess hospital bed capacity may generate more hospital stays, this theory holds that a surplus of physicians all attempting to maintain their incomes would lead—in the absence of any controls—to excess delivery of services. Repeated efforts to demonstrate this have been inconclusive.²⁸ It is not clear that physicians actually modify their medical practice in order to maintain a "target income." Still, if the projected surplus does in fact appear, there might be greater pressures on physicians to increase the number of services they furnish to each patient. Some people believe that it may eventually be necessary to consider reducing the supply of physicians (or curtailing their working hours).

This has actually been attempted in one Canadian province, British Columbia. A physician who wants to participate in the health program that covers all citizens of the province must have a billing account, and since 1985 the number of accounts has been limited (limits vary by specialty and geographic area). A physician who fails to obtain a billing number cannot earn a living as a physician. Critics of the system contend, however, that British Columbia is merely exporting its physician surplus to other provinces or to the United States.²⁹ Given the political problems health planners in the United States have experienced in trying to close hospitals, it seems unlikely that British Columbia's efforts could be reproduced here, with government regulators telling new medical school graduates to find some other profession. However, there are proposals to achieve the same goal through private means. Some of the more ambitious "managed care" agendas discussed in the final section of this report contemplate enrollment of the entire population in health maintenance organizations (HMOs) or other structured delivery systems that would match their resources to the needs of the enrolled population; this approach would potentially reduce employment opportunities for physicians.³⁰

²⁸ See Louis F. Rossiter and Gail R. Wilensky, "A Reexamination of the Use of Physician Services: The Role of Physician-Initiated Demand," *Inquiry* 20 (2) (Summer 1983): 162-172; Kathryn M. Langwell and Lyle M. Nelson, "Physician Payment Systems: A Review of History, Alternatives and Evidence," *Medical Care Review* 43 (1) (Spring 1986): 5-58.

²⁹ Morris L. Barer, "Regulating Physician Supply: The Evolution of British Columbia's Bill 41," *Journal of Health Politics, Policy, and Law* 13 (1) (Spring 1988): 1-25.

³⁰ For example, Alain Enthoven has characterized the "buy right" scheme advanced by Walter McClure as requiring that "good-quality, efficient doctors prosper while others are induced to retire." Alain C. Enthoven, "Managed Competition in Health Care and the Unfinished Agenda," *Health Care Financing Review*, 1986 Annual Supplement, 105-119.

Reimbursement Reform

Proposals for reimbursement reform begin with the premise that traditional payment systems, under which providers receive their full costs or charges for whatever services they choose to furnish, encourage inefficiency and the delivery of unnecessary care.

The simplest type of reform is for payers to set fixed prices for defined units of service, such as a day of inpatient care or a physician office visit. However, this approach may not reduce costs if providers are able to modify the volume or nature of the services they provide to make up for the lost revenue on individual services. For this reason, the focus of reimbursement reform proposals is on developing pricing mechanisms that give providers incentives to control both volume and unit cost.

This is generally accomplished by redefining the commodity the insurer is purchasing. Instead of paying for individual units of service, the insurer makes one payment for an episode of care (as in Medicare's prospective payment system, PPS), for overall treatment of a patient during a given time period (capitation), or for treatment of an entire population (as in Canada's global budgeting system for hospitals). These approaches may be seen as aligned on an ascending scale depending on the degree of aggregation of the unit being purchased, with per-case payment at the low end and payment for an entire patient population at the other. In all cases, however, the aim is to define in advance the total amount of resources the provider may consume in furnishing treatment to a patient or group of patients.

Per-case payment and capitation give the provider an incentive to perform more efficiently in treating individual patients, either reducing the cost of producing each unit of service or reducing the number of units furnished to each patient. These approaches may therefore be seen as alternatives to external utilization controls. Global budgeting defines the total resources available for treating all patients, and may be seen as an alternative to health planning.³¹ Reimbursement controls have the same goals as direct regulation of medical practice and supply, but shift the responsibility for decision-making from the third-party payer or the government to the actual providers of care. In order to live within the established rates or budgets, the providers must be self-regulating; they must make

³¹ In practice, the Canadian system uses both global budgeting and health planning. However, some of the rate regulation systems in the United States have explicitly superseded the health planning system. A facility that has obtained a certificate of need for expansion may proceed only if the rate commission approves the necessary increase in capital costs. For a discussion of the interplay of planning and rate regulation, see Brown, *Common Sense Meets Implementation*.

the same sorts of treatment and resource allocation decisions that would otherwise have been imposed externally.

As the Medicare program has demonstrated, it is possible for a single payer with sufficient market power to adopt such reimbursement changes on its own.³² The effects of this unilateral approach in a pluralistic system are uncertain. While some providers may be driven to improve their efficiency, others may instead respond to shortfalls in reimbursement from one payer by raising charges to other groups, those without the market power to dictate prices. The possibility of "cost-shifting" may mean that savings for one purchaser are not translated into real reductions in total system expenditures.

In a sufficiently competitive market, the providers' ability to engage in this "cost-shifting" may be limited. A hospital may face, not only payment limits under Medicare and Medicaid, but pressure from private insurers or employer groups to grant price discounts in order to be assured of an adequate market share. Characteristics other than efficiency may determine a provider's success in the face of these competing demands. For example, a suburban non-teaching hospital with few uninsured patients may be at a relative advantage as compared to a center city teaching facility with a heavy uncompensated care load. Individual purchasers who reduce their costs by favoring the suburban hospital may leave the society to find some other means of subsidizing essential facilities that are handicapped in price competition.

A system in which multiple payers negotiate individually with providers may, then, lead either to cost-shifting or to a situation in which price concerns override other societal goals, such as medical education and charity care. For this reason, some people argue that real efficiency can be achieved only if all payers are paying under the same rules.

Uniform ratesetting is common in other industrialized nations, both those with single-payer health insurance systems (as in Canada) and those where many different entities provide insurance (as in West Germany). The experience in the United States is limited to experiments in a few States beginning in the 1970s. Federal waivers of Medicare and Medicaid rules made it possible for those two payers to participate in the programs on a demonstration basis, while State laws compelled participation by private insurers and individual payers, resulting in an "all-payer" system.

³² As the Medicaid experience has shown, adoption of payment restraints by a payer with too small a market share may reduce access for the payer's enrollees. For example, low reimbursement rates are the major reason physicians decline to participate in the Medicaid program. See Congressional Research Service, *Medicaid Source Book*, 448-454.

Medicaid law now permits any State to include Medicaid in such a system, and Medicare may be included if the State can show that its system controls costs as effectively as PPS. However, full "all-payer" systems continue only in Maryland and in part of New York State. Several other States operate "partial-payer" systems that include all payers except Medicare.³³ These systems have generally used the price aggregation approaches described above. That is, they either establish a rate for total treatment of a case (as under PPS) or they establish a total budget for a hospital during a year, setting prices for the hospital in such a way as to achieve a target revenue amount.

It has been shown that, in 6 States with ratesetting systems, annual increases in cost per admission were consistently 3 to 4 percentage points below the national average from 1976 to 1984. During the same period, however, other States saw a drop in admissions per capita, while admissions in the ratesetting States were stable. As a result, the difference in growth in per capita rates of spending was not so striking: per capita costs rose at an annual rate of 11.5 percent a year in the ratesetting States and 13 percent a year in other States.³⁴ In addition, the ratesetting States had much higher costs at the outset than most other States. Some observers have questioned whether ratesetting could have achieved comparable savings in areas where costs were lower to begin with.³⁵

Evidence from other countries with universal ratesetting systems suggests that greater savings may be possible. In Canada, where the provinces establish global budgets for each hospital, hospital expenditures per capita were one-third lower than in the United States in 1985. (Similar systems in other industrial nations have been less successful.)³⁶ As admission rates are not markedly lower, there is considerable uncertainty about the sources of the difference. Some of the saving may be in administrative costs, simply because the hospitals do not need to meet the paperwork requirements of multiple payers. The rest of the difference is often attributed to differences in the intensity of the services furnished to each patient. Whether these differences reflect "underservice" in Canada or

³³ Maine's system takes hospitals' Medicare revenues into account when determining what the hospitals may charge other payers, thus achieving overall budgetary control without direct Medicare participation. This approach has recently survived a legal challenge by hospitals.

³⁴ Carl J. Schramm, Steven C. Renn, and Brian Biles, "New Perspectives on State Rate-Setting," *Health Affairs* 5 (3) (Fall 1986): 22-33.

³⁵ Charles L. Eby and Donald R. Cohodes, "What Do We Know About Rate-Setting?" *Journal of Health Politics, Policy, and Law* 10 (2) (Summer 1985): 299-327.

³⁶ Organisation for Economic Co-Operation and Development, *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries* (OECD Social Policy Studies No. 4.) (Paris: 1987), 63.

“overservice” in the United States is the subject of continuing debate.³⁷

In a sense, the statistical evidence may be beside the point. An all-payer system could in theory fix its prices at any level, with the potential consequence of reduced access or quality if the prices are set too low. The available data may thus be taken as indicating, not the savings that could hypothetically be achieved, but the savings that were politically feasible in specific States during a specific period. Continuing pressure by consumers and providers for the adoption of new medical technologies may limit the ability of ratesetting systems to restrain expenditure growth over the long term. Even in Canada, overall medical expenditures outpaced inflation by 2.9 percent a year in the period 1980–87, almost the same as the 3.0 percent annual rate observed in the United States in the same years.³⁸ The ultimate efficacy of reimbursement controls may depend, in the same way that the success of health planning depends, on the political will to constrain health care consumption.

That political will might in turn depend on perceptions of the impact of reimbursement controls on the quality of care. The effect of Medicare’s prospective payment system, for example, has been argued continuously since its implementation in 1983. One of the immediate responses of hospitals to the incentives of the new system was to shorten the average length of stay in the hospital for each Medicare patient (although average length of stay had already been dropping for several years). Opponents of the new system have contended that patients were being discharged “quicker and sicker,” transferred to their own homes or to nursing homes at a stage in their recovery when they still required hospital-level care. Because of a lack of satisfactory measures of medical care outcomes for large populations, evidence on this issue remains largely anecdotal. Still, the possibility that there has been a deterioration in quality of care for at least some Medicare patients since the implementation of PPS cannot be ruled out. The hospitals themselves argue that current payment levels are insufficient to maintain adequate quality. At the same time, the Administration and the Prospective Payment Assessment Commission (the independent commission that reviews PPS) have argued that hospitals are still not operating at peak efficiency and that further payment restraint is needed to provide continued incentives for cost reduction.³⁹

³⁷ For a variety of views on this subject, see the series of articles on Canada’s hospital system in *Health Affairs* 7 (5) (Winter 1988).

³⁸ Schieber and Poullier, *International Health Care Expenditure Trends*: 1987.

³⁹ U.S. Prospective Payment Assessment Commission, *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services* (Washington, D.C.: Government Printing Office, March 1989); For a recent review of hospital cost responses to PPS, see Steven H. Sheingold, “The

This debate illustrates one potential dilemma in the strategy of achieving savings by relying on the political process to limit the financial resources available to providers. On the one hand, legislators driven by budgetary concerns may continue to ratchet down spending limits until they have clear evidence that quality has been seriously affected. On the other hand, provider or constituent pressure may lead them to relax those limits before the providers have done everything possible to improve their efficiency. Because no one knows the ideal amount to spend on medical care, some people say that this process can never achieve equilibrium and that cost control efforts should instead depend on the process through which other sectors of the economy achieve “correct” spending levels: the free market. Proposals for encouraging competition in health care represent the last of the strategies to be reviewed in this report.

Competition

The idea of reducing health care costs by promoting competition in the health care marketplace was first advanced in the 1970s. Some analysts, arguing that such initiatives as rate regulation, health planning, and utilization review had been compromised by political interference, contended that the free market was better equipped to control costs than Government was. By the early 1980s, this view had wide currency and had become the official policy of the Reagan Administration. Since then, there has been a continuing debate between advocates of competition and those who favored further regulatory interventions by Government. The debate has been complicated by a lack of agreement over what “competition” consists of. What is the health care market? Who are the purchasers, and what are they buying?

In a simple market, hospitals and physicians would compete directly for the individual consumer’s dollar. The consumer would pick the best values just as he or she does when buying any other commodity. As was suggested in the discussion of cost-sharing, it is not clear that consumers are capable of making such evaluations; moreover, many purchasing decisions are made by physicians on their patients’ behalf, rather than directly by consumers. Finally, because few people can afford the costs of care for a major illness, most of the consumer’s dollar is spent on health insurance, not on medical care itself. As was suggested earlier, this is true even when the insurance plan imposes cost-sharing requirements on enrollees, because most health care costs are incurred by a relatively

First Three Years of PPS: Impact on Medicare Costs,” *Health Affairs* 8 (3) (Fall 1989): 191–204.

small number of high-cost cases. For this reason, most proponents of competition are really talking about price competition among insurers, and only indirectly among providers.

If the insurer is—as traditional health insurance plans were—a passive payer for services obtained by policyholders, there is little room for serious price competition. The only element of cost that the insurer can control is its own administrative cost. Competition, if any, may turn on such non-price factors as reputation or the insurer's ability to screen out high-risk applicants.⁴⁰

Competition among insurers can result in real cost savings only if the insurers have some influence on the costs of health care itself. In this model, insurers compete to offer lower prices by acting as prudent purchasers, proxies for the rational consumer. The insurers are selling a new product, no longer simply insurance, but “insured health care.” To some extent, this new insurance market has already arrived. As was suggested earlier, most insurance plans, both public and private, have adopted some utilization control measures. Very few insurers are still passive bill-payers.

Once all insurers have adopted these basic cost control measures, further competition would presumably require more aggressive interventions by insurers in the health care system. Proponents of competition contemplate a marketplace in which insurers develop structured delivery systems, with the highest profits going to those whose networks are most efficient. The prototype for these systems is the HMO. More recently, some insurers have been experimenting with hybrid programs, such as “point-of-service plans,” that are less structured and provide somewhat greater flexibility to enrollees.

Health Maintenance Organizations—A health maintenance organization (HMO) is a form of health insurer; like any other insurer, it accepts financial responsibility for a defined set of health care benefits in return for a fixed monthly per capita premium. Unlike other insurers, HMOs directly provide or arrange for health care services, through affiliated physicians, hospitals, and other providers. The enrollees covered by the HMO agree to obtain all services, except emergency and out-of-area care, from or with the authorization of the HMO or its affiliated providers. The

HMO has no liability to pay for unauthorized non-urgent care obtained outside the organization. Ordinarily, the enrollee's point of entry into the system is through a single primary care provider, who functions as a “gatekeeper,” determining when a patient may see a specialist or be admitted to the hospital. The HMO exerts further administrative controls on use of services through authorization mechanisms and/or treatment protocols. HMOs also use a variety of other cost-saving techniques, such as negotiated discounts with providers and payment mechanisms that place individual providers at risk for the costs of the services they furnish or order.

The particular cost-saving techniques adopted by HMOs and other “managed care” plans are not fundamentally different from the regulatory approaches described in the preceding sections. An HMO imposes external utilization review on its participating providers and may develop practice guidelines or protocols. Staff or group practice model HMOs (those that employ physicians on a full-time basis) impose supply constraints, limiting available resources to those needed by their membership. Individual practice associations (IPAs, whose physicians practice in their own offices and see a mix of HMO and non-HMO patients) use payment methods that create financial incentives to control utilization, such as capitation or expenditure targets.

One additional cost-saving approach that was once unique to HMOs is “gatekeeping.” Under a gatekeeping approach, a patient receives all non-emergency care from, or with the authorization of, a single primary care provider. The provider thus functions as a “gatekeeper,” preventing the enrollee from independently accessing specialists or other services and presumably managing the overall care of the patient. The extent to which gatekeeping produces savings over and above those provided by the other cost-saving techniques adopted by HMOs is uncertain. The results of one experiment, the SAFECO health plan operated by United HealthCare in the early 1980s, suggest that gatekeeping alone has little effect on overall cost. While primary care providers reduced the number of referrals to specialists, they were unable to control the behavior of the specialists once a referral had occurred. There was no meaningful reduction in hospital admissions, 70 percent of which were controlled by the specialists.⁴¹ Greater success

⁴⁰ Alain Enthoven has summarized the alternatives to price competition: “[S]election of preferred risks, market segmentation, product differentiation that raises the costs of comparing products, discontinuity in coverage, refusal to insure certain individuals or exclusion of coverage for treatment of pre-existing medical conditions, biased information regarding coverage and quality, and erection of entry barriers [that is, to new competitors].” Alain C. Enthoven, “Managed Competition of Alternative Delivery Systems,” *Journal of Health Politics, Policy and Law* 13 (2) (Summer 1988): 305–321.

⁴¹ Stephen Moore, Diane Martin, and William Richardson, “Does the Primary-Care Gatekeeper Control the Costs of Health Care? Lessons from the SAFECO Experience,” *New England Journal of Medicine* 309 (22) (December 1, 1983): 1400–1404; For the extent to which specialty referrals may determine overall costs, see John K. Glenn, Frank H. Lawler, and Mark S. Hoerl, “Physician Referrals in a Competitive Environment: An Estimate of the Economic Impact of a Referral,” *Journal of the American Medical Association* 258 (14) (October 9, 1987): 1920–1923.

has been reported by some State Medicaid programs, which have established "primary care case management" programs for segments of their covered populations. Gatekeeping reduced such inappropriate behaviors as the use of emergency rooms for primary care. However, the utilization patterns addressed by these programs may be characteristic of Medicaid beneficiaries in the inner city and not of other groups; it is not clear that equivalent savings could be achieved with a general population. There is some evidence that most patients' care is already "managed" by their primary care physicians, at least to the extent that it is managed under formal gatekeeping arrangements.⁴²

Aside from the uncertain effects of gatekeeping, managed care depends on the same kinds of interventions in medical care practice, supply, and financing that might otherwise be attempted on a regulatory basis. The difference is that, instead of relying on the political process to make decisions about the allocation of health care resources, managed care privatizes these decisions. The choice among alternative cost control methods—and the stringency with which these methods will be applied—will be made by the free market. The fundamental contention of proponents of the competitive approach is that the market can impose discipline on the health care system that cannot be imposed through external regulation.

This contention rests on two key assumptions: first, that buyers will, all other things being equal, select the most cost-effective plan; second, that managed care offers greater cost-saving potential than the various regulatory controls described earlier.

One critical factor has made it difficult to generalize about the efficacy of HMOs as a cost-saving approach: the problem of "biased selection" in systems that allow a choice between a conventional health insurance plan and an HMO. Numerous studies of such "dual choice" employer group plans have shown that the members of the group choosing the HMO option used fewer health services before their enrollment than persons who chose a conventional plan. Similar patterns have been observed in Medicare HMO enrollment.⁴³ This does not necessarily mean that HMO enrollees were healthier. Studies using self-reported condition and similar limited measures of health status have found no difference between HMO and indemnity enrollees. It may be, then, that HMO enrollees

are simply less prone to seek health services, regardless of their condition.⁴⁴

In groups that have no HMO option but do offer a choice between high- and low-option plans the common selection pattern is for the higher users of services to choose the more comprehensive plan.⁴⁵ In most group health programs offering a choice between HMOs and conventional plans, the HMO options offer more comprehensive coverage, with less enrollee cost-sharing, than even a high-option conventional plan. That higher users of services still prefer the conventional plan suggests that non-financial aspects of HMOs affect the decision, such as limited choice of providers, bureaucratic constraints on treatment, or waiting time for non-urgent care. There is stronger evidence of biased selection for staff and group model HMOs, the most restrictive, than for IPAs, which are less likely to disrupt enrollees' traditional ways of obtaining medical care.

Possible solutions to the problem of selection bias will be discussed further below. One immediate consequence, however, is that the differences between the populations in HMOs and conventional plans have made it difficult to determine whether HMOs are actually more efficient than other insurers. Only one major study has corrected adequately for this problem. In a second component of the RAND Health Insurance Experiment (HIE) cited earlier, enrollees were randomly assigned to the Group Health Cooperative of Puget Sound and an equally comprehensive conventional plan; neither plan required cost-sharing. This arrangement allowed comparisons of efficiency with identical benefits and populations with comparable health needs. The results strongly confirmed the cost-saving potential of the HMO. The HMO enrollees had 40 percent fewer hospital admissions; their use of ambulatory services was about the same as that of the conventional enrollees. Overall, costs for the HMO group were estimated to be 28 percent lower than for the control group.⁴⁶ There were no perceived effects on quality; measures of health outcomes were generally the same for both groups.⁴⁷

⁴² Fred J. Hellinger, "Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence," *Health Care Financing Review* 9 (2) (Winter 1987): 55-63.

⁴³ Robert W. Broyles and Michael D. Rosko, "The Demand for Health Insurance and Health Care: A Review of the Empirical Literature," *Medical Care Review* 45 (2) (Fall 1988): 291-338.

⁴⁴ Willard G. Manning, et al., "A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services," *New England Journal of Medicine* 310 (23) (June 7, 1984): 1505-1510.

⁴⁵ John E. Ware, Jr., et al., "Comparison of Health Outcomes at a Health Maintenance Organisation With Those of Fee-for-Service Care," *Lancet* (May 3, 1986): 1017-1022. One group, low-income HMO enrollees with existing health problems, had poorer outcomes, possibly because of difficulty dealing with the HMO's internal bureaucracy.

⁴² A.J. Dietrich, et al., "Do Primary Physicians Actually Manage Their Patients' Fee-for-Service Care?" *Journal of the American Medical Association* 259 (21) (June 3, 1988): 3145-3149.

⁴³ For a review of the evidence, see General Accounting Office, *Medicare: Increase in HMO Reimbursement: Would Eliminate Potential Savings*. Report to the Chairman, Subcommittee on Health, House Committee on Ways and Means (Washington, D.C.: November 1989). [GAO/HRD-90-38]

While the HIE findings are persuasive, two factors may limit the general applicability of the results. First, the study was conducted in the late 1970s; the comparison plan was the passive bill-payer prevalent in the insurance industry in that period, with no utilization control mechanisms. The more recent adoption by conventional plans of some of the cost-control measures once associated only with HMOs may mean that the difference in efficiency between the two types of plan has narrowed.

Second, the HMO used in the Health Insurance Experiment was a highly structured group-practice plan with many years of operating experience. Much of the growth in the industry in recent years has involved a different type of HMO, the individual practice association (IPA), which contracts with independent physicians who see a mix of HMO enrollees and other kinds of patients. There is evidence that these more loosely structured HMOs have not achieved savings comparable to those observed in the HIE.⁴⁸ Physicians may not modify their styles of practice in treating HMO enrollees if those enrollees constitute only a small share of their practice. In addition, some people believe that HMOs cannot impose cost-consciousness on practitioners who have not "signed on" to the concept of more efficient and less resource-intensive practice. Because so little is still known about the relative efficacy of different medical practices, external utilization controls may not be able to override individual physicians' judgment in many cases. The greater success of the "closed panel" plan, whose physicians treat HMO enrollees exclusively, has been attributed by some observers to the possibility that these plans attract physicians who are temperamentally more prone to conservative medical practice.

Because closed panel plans maintain their own medical facilities, they require greater start-up funding than IPAs. Federal funds were available to develop such plans in the 1970s, but new plans must now rely on private investment. Investors have favored IPAs, not only because they require less capital, but also because the wider selection of physicians makes them more attractive to consumers. This attraction may, however, be purchased at the price of reduced efficiency.

Finally, while some types of HMOs or similar organizations may be able to reduce costs relative to conventional plans, it is not clear that they have so far reduced *growth* in health care costs. Data from 1961 through 1981 suggest that HMOs may instead achieve

a one-time saving, after which costs rise at the same rate as those for other insurance programs. One explanation that has been offered is that providers in HMOs are as likely as other providers to use new medical technologies.⁴⁹ More recent data suggest that HMO premium increases have continued to resemble those of conventional insurance plans. The average HMO premium increase during 1988 was 17.2 percent, very close to the 19 percent increase for all employer coverage cited at the beginning of this report.⁵⁰

That HMO cost increases have paralleled those of other insurers does not necessarily mean that HMOs have reached the limit of their cost-saving potential. Because competition among health insurers was relatively limited until recent years, many HMOs may not have faced the market pressures that could induce them to achieve greater savings. The next section reviews proposals to strengthen competition.

Competition and Consumer Choice—The competitive strategy depends on the willingness of consumers to choose the most cost-effective plans. As was suggested earlier, the consumers most likely to incur high costs may be least likely to choose the most efficient option. The problem of biased selection might persist even if conventional insurance plans were to disappear and consumers were able to choose only among managed care options. (Some industry analysts believe this will occur in the near future, chiefly because employers will refuse to offer conventional plans.) It is possible that the most costly patients, given a choice among competing managed care plans, would choose the plan that was least restrictive and potentially least able to achieve cost savings. The most efficient plans might continue to enroll the healthiest patients, for whom only limited savings are possible.

Some people believe that biased selection is largely attributable to the fact that consumers are economically sheltered from the cost of their choice of plan, because most of the premium is paid by the employer. Various schemes have been advanced to make the employee more cost-conscious. For example, the employer's contribution might be tied to the cost of the least expensive offering, with the employee bearing the full cost of the difference between that plan and other more expensive options.

⁴⁹ Joseph P. Newhouse, et al., "Are Fee-for-Service Costs Increasing Faster Than HMO Costs?" *Medical Care* 23 (8) (August 1985): 960-966.

⁵⁰ InterStudy, *The Bottom Line: HMO Premiums and Profitability, 1988-1989* (Excelsior, Minn.: 1989). Staff and group model HMOs generally had lower increases, possibly confirming their greater efficiency. However, these HMOs also tend to be older than IPAs; age of the HMO was also a determinant of the rate of increase.

⁴⁸ For the most recent findings, see Alan Hillman, Mark Pauly, and Joseph Kerstein, "How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?" *New England Journal of Medicine* 321 (2) (July 13, 1989): 86-92.

However, selection bias can occur even when the choice of the more expensive plan has real financial consequences for the enrollee. Under the Federal Employees Health Benefits Program (FEHBP), the monthly employee share of premium costs in 1990 ranges from \$20.54 in the least expensive high-option HMO to \$234.07 in the most costly high-option conventional plan, a difference of \$213.53 per month.⁵¹ Under one possible fixed contribution scheme, the Federal share of both plans would be set equal to the full cost of the HMO (\$82.16); the employee share would then be zero for the HMO and \$265.29 for the conventional plan. If some Federal employees or annuitants are already willing to pay 11 times as much as others in order to obtain the conventional plan, it is not clear that even this change would cause all of them to shift to the HMO. For at least some subset of enrollees, the preference for unrestricted coverage is apparently sufficient to override even strong financial incentives.

One possible solution to the problem of enrollee self-selection is to abandon multiple choices and oblige all members of a covered group to enter a single plan, one selected by the employer or other buyer from among competing plans. Assuming that employers disregarded their own personal plan preferences and chose the least costly option, this approach would theoretically lead to competition among plans on the basis of efficiency. However, both employers and HMOs have been hesitant to enter into arrangements under which enrollees are unwillingly locked into a highly restrictive plan. For this reason, there have evolved arrangements even less restrictive than IPAs, known as open-ended or point-of-service plans.

The predecessor of these plans is the preferred provider organization (PPO). PPOs negotiate discounted rates with certain providers. Enrollees are given a financial incentive, in the form of reduced deductible or coinsurance requirements, to obtain care from providers participating in the PPO network. However, payment will be made under the plan for services furnished by any provider. PPOs thus differ from HMOs, which deny payment altogether for unauthorized non-emergent care provided by providers outside the HMO network. While some PPOs have adopted managed care techniques, such as the use of gatekeepers, most of the savings from a PPO are expected to result from encouraging enrollees to use the participating providers.

The newer, open-ended plans are hybrids, combining some features of HMOs and PPOs. Typically, the

plan operates a structured health care system comparable to that of an IPA-model HMO. Enrollees are expected to access the system through a primary care gatekeeper and obtain services from other network providers upon referral by the gatekeeper. Like an HMO, the plan also imposes external utilization controls and negotiates price discounts with providers. As in a PPO, enrollees are free to use non-network providers for covered services, but must pay higher cost-sharing amounts if they choose to do so. Enrollees are also subject to higher cost-sharing if they use specialists within the network without the authorization of the gatekeeper.

Open-ended plans have been adopted by some employers as the single plan available to their workers, replacing systems in which the workers had a choice between conventional and HMO options. Their attraction has been that they overcome the possible selection bias in dual choice systems by enrolling all employees in an HMO-like program. At the same time, they can reduce the employee resistance that would probably greet a proposal for universal HMO enrollment, because they offer employees the safety valve of being able to choose non-plan providers.

Officials of some major insurers that have experimented with open-ended plans in multiple markets report that the plans appear to be reducing the rate of health care cost increases, relative to the increases for their conventional offerings in the same markets.⁵² Because these plans began operations only very recently, the data required for an objective evaluation are not yet available. Even PPOs, which have existed for a decade, have never been the subject of a controlled study. Some preliminary findings, however, suggest that the safety valve that makes PPOs attractive is potentially a serious weakness, one which may carry over to the newer hybrid plans.

One recent study of a PPO found that enrollees used the PPO's providers for preventive care and minor illnesses, but went outside the network about half the time for specialty care, major surgery, and hospitalization without surgery.⁵³ One study found a similar pattern among PPO enrollees who were actually employees of one of the providers in the PPO network.⁵⁴ While these findings are not definitive, they suggest a dilemma that may be common to both PPOs and the newer types of managed care plans. If the price for going out of plan is not punitive, en-

⁵² Personal communication with officials of Prudential and CIGNA.

⁵¹ The conventional plan is national, while HMOs are offered only in specific locations. The comparison presented here applies only in one area (Tampa, Fla.) and represents the extreme of variation in the FEHBP system.

⁵³ Annemarie Wouters and James Hester, "Patient Choice of Providers in a Preferred Provider Organization," *Medical Care* 26 (3) (March 1988): 240-255. The results may not be fully representative, because the PPO studied was somewhat skewed towards primary care providers.

⁵⁴ Paula Diehr, et al., "Use of a Preferred Provider by Employees of the Preferred Provider," *Health Services Research* 23 (4) (October 1988): 537-554.

rollees may obtain much of their care outside the network; if the price is set high enough to deter outside utilization, the plan may lose its relative attractiveness.

Both solutions to the biased selection problem, higher premiums for the non-HMO plan or higher cost-sharing for using non-HMO providers, may then face the same potential barrier: the highest-risk enrollees, those for whom the greatest potential savings presumably exist, may be willing to pay much more out-of-pocket to retain free choice of providers and avoid bureaucratic restrictions. While the problem might be overcome by making the cost of unrestricted health care prohibitive, this solution may be foreclosed by the potential strain on labor relations (or, in the case of public programs, political resistance).

One other solution that has been proposed is to go to the roots of consumer resistance to managed care, the concern about quality. Some analysts argue that, because consumers have little information about the relative quality of different medical care providers, they must rely on "signals" of quality sent out by various providers, such as the use of elaborate technology or aggressive medical treatment styles.⁵⁵ If the persons with the highest expectation of requiring medical services will accept financial sacrifices to avoid managed care programs, this may be because they cannot evaluate the care offered by such programs and wish to remain free to seek out the providers who more actively signal quality. This preference might be overcome if consumers had reliable data on the actual quality of the care furnished by different providers or provider systems such as HMOs.

This view has led to such proposals as the "buy right" plan advanced by Walter McClure of the Center for Policy Studies in Minnesota. Under this plan, a community would collect and make available to consumers uniform data on patient outcomes from

all providers. Consumers would then be in a position to determine whether the higher cost providers were actually furnishing superior care and could thus make rational purchasing decisions. The proposal assumes that the community can agree on objective measures of quality. Past efforts to develop uniform bases of comparison have been controversial. For example, the annual release by the Health Care Financing Administration of mortality data for Medicare beneficiaries in hospitals has been criticized on the grounds that numerous factors other than relative proficiency can affect the death rates of hospital patients. Highly specialized facilities may be treating the most seriously ill patients; facilities serving a low-income population may find that more of their patients have delayed medical treatment beyond the point at which they could be helped. Full implementation of the "buy right" strategy might have to wait until research can provide acceptable standardized outcome measures.

Assuming that those measures can be developed, how would competition then work? Consumers would be fully informed about the relative price and quality of competing health plans, and would thus be equipped to make medical care purchasing decisions in the same way that they decide about other purchases. Proponents of competition argue that the power of the market would then compel all providers to make steady improvements in both quality and efficiency. However, if the health care market could be induced to evolve in the same way as other markets, it is not necessarily the case that the end product would be a single class of providers uniformly striving to achieve the same goals. The health care market could instead be segmented in the way that the markets for other goods and services are; there might be economy and luxury health plans just as there are economy and luxury automobiles. Improving the information available to health care consumers might mean only that buyers would be better able to distinguish between the two, not that the distinction would cease to exist. Whether Americans are prepared to accept the same price/quality tradeoffs in buying medical care that they do in buying other products is an open question.

⁵⁵ For an elaboration of this theory, see James C. Robinson, "Hospital Quality Competition and the Economics of Imperfect Information," *Milbank Quarterly* 66 (3) (1988): 465-481.

MEDICAL MALPRACTICE

Paul Weiler and Troyen A. Brennan *

INTRODUCTION

Medical malpractice is the branch of the law that deals with injuries suffered by patients in the course of their treatment by doctors or other health care providers. The legal doctrines in this area remain firmly rooted in the traditional tort-fault principle—a doctor is liable for a patient's injuries if and only if these injuries were caused by the doctor's negligence. Lawyers and judges have long debated the question of whether this legal regime secures adequate compensation and corrective justice for already injured patients, and safer and better quality care for future patients. In the past two decades this debate has emerged into the popular and political arena, as doctors and hospitals have confronted steep and sudden increases in malpractice litigation and premiums.

In the last year, the country has emerged from its second outburst of malpractice premium increases. Insurers maintained that premiums were driven upwards by increasing rates of claims and increasing average payments on successful claims. Premium hikes from 1983 through 1986 culminated in a total premium bill for malpractice liability insurance of \$6 billion in 1987, up from \$60 million in 1960 (while medical costs were rising to over \$500 billion, up from \$25 billion in 1960). Over the last two years, premiums have moderated, and in some high-risk states have even fallen.¹ However, for reasons we will sketch in this

paper, it is doubtful that the spiral of the mid-1980s will be the last. We can expect, and we should be better prepared to handle, another bout of the problems inherent in our system of malpractice litigation.

Many of these problems are rooted in the volatility of malpractice insurance premiums. Historically, malpractice premiums have followed a path of sudden steep increases followed by a few years of moderation.² After a slow, but steady upward trend throughout the 1960s, total premiums doubled from 1974 to 1976, reaching the billion dollar mark in that latter year.³ By 1982, the nation's bill for premiums had passed \$2 billion, and then spiralled again to \$6 billion by 1987.⁴

One should put these aggregate costs of medical malpractice insurance in perspective, by relating them to the total health care costs for the nation. In 1987, when health care costs were roughly \$500 billion, medical malpractice premiums consumed slightly more than one percent of our health care dollars (up

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¹ See "Medical Malpractice Insurance Rates Fall," *Wall Street Journal*, April 28, 1989, B-1 and "Costs of Medical Malpractice Drop After an 11 Year Climb," *New York Times*, June 11, 1989, A1, col. 2.

In 1986 and 1987, during the height of the increase in premiums, predictions regarding the costs of premiums in 1988 ranged between 8.5 and 10.2 billion dollars. See Department of Health and Human Services, *Report of the Task Force on Medical Liability and Malpractice* (August 1987) 4.

² Throughout this discussion, we rely on several empirical studies of premiums. Among these are: National Association of Insurance Commissioners, *Medical Malpractice Closed Claims, 1975-1978* (1980); General Accounting Office, *Medical Malpractice Insurance Costs* (Washington, D.C.: 1986); General Accounting Office, *Medical Malpractice: Characteristics of Claims Closed in 1984* (Washington, D.C.: 1987); New York State Department of Health, *Physicians Malpractice Claims Closed 1980-1983* (1986) (NY Closed-Claims Study); Florida Academic Task Force for the Review of the Insurance and Tort System, *Preliminary Fact Finding Report on Medical Malpractice* (1987) (Florida Academic Task Force). More recent data includes: Danzon, "Medical Malpractice Liability," in *Liability: Perspectives and Policy*, eds. Litan and Winston (1988), 101-127; Sloan and Bovbjerg, *Medical Malpractice: Crisis Response and Effects* (Health Insurance Association of America, 1989); and *Physicians and Surgeons Update: The Saint Paul's 1989 Annual Report to Policy Holders* (1989). This latter document has the most recent data available regarding the premiums of St. Paul's, the major national malpractice carrier, which announced there will be a 14.1 percent decrease effective July 1, 1989.

³ See Danzon, *The Frequency and Severity of Malpractice Claims*. (Santa Monica, Calif.: The Rand Corporation) (R-2870-ICJ/HCF), 1982.

⁴ The General Accounting Office had estimated that insurance costs for physicians in hospitals increased from 2.5 billion dollars in 1983 to 4.7 billion dollars in 1985. General Accounting Office, *Medical Malpractice: Framework for Action* (Washington, D.C.: 1987) 2. The American Medical Association estimated that professional liability premiums were 5.7 billion dollars in 1985. American Medical Association, *Trends in Health Care* (Chicago: AMA), 1987.

from .5% of health care dollars in 1960).⁵ True, \$4 billion of these premiums charges were borne by physicians, as compared with \$103 billion spent on physicians services. But while malpractice premiums do represent a somewhat higher share of physician services, four percent of gross physician revenues is not an extraordinarily high bill to pay for liability insurance.

These overall figures, however, tend to understate the acuteness of the problem in specific situations. There is a great deal of variation in premiums by specialty and by geographic location.⁶ For example, while general practitioners in Indiana or allergists in Arkansas paid less than \$2000 in 1985,⁷ obstetricians or neurosurgeons in New York City were paying (or having paid on their behalf) from \$150,000 to \$200,000 annually.⁸ Even more disruptive is the fact noted earlier that premiums increased very quickly in the mid 1970s and in the mid 1980s. For instance, in many large states, surgical and obstetrical premiums increased three to four hundred percent in the period from 1980 to 1986.⁹ In addition to these financial expenses of insurance premiums, more and more physicians faced the personal stress of lawsuits brought by their own patients.

Beyond these fairly well documented concerns about insurance premiums and litigation stress are certain other costs of medical malpractice. First, premiums are not the only social costs attributable to malpractice litigation. Physicians and their representatives emphasize that professional liability premiums are smaller than the costs of defensive medicine. The American Medical Association (AMA), for instance, estimates that in 1985, the total cost of defensive medicine was \$11.7 billion for physician services alone.¹⁰ Others are less certain of the costs associated with defensive medicine, partly because the concept

itself is elusive.¹¹ Defensive medicine is defined as care provided solely to decrease the potential for a lawsuit, in contrast to care that helps diagnose or treat a patient's ailment. What some term defensive practice, others might see as appropriate care elicited by the incentive effect of malpractice litigation. However, adding the direct costs of litigation to those of defensive medicine, some researchers calculated that in 1984 malpractice litigation cost \$13.7 billion,¹² (just prior to the last big jump in premiums).

Another social cost is decreased access to care when malpractice litigation drives some physicians out of certain specialties and out of particular geographic locations. This problem is seen most sharply in studies of obstetrical services in low-income areas, where obstetricians, family practitioners or clinics are reducing this part of their practice, they say, due to the economic interaction of Medicaid cost containment and rising malpractice premiums.¹³ Indeed, the Institute of Medicine's recent report on the delivery of obstetrical care focused on this particular issue, and emphasized that some relief from the burden of malpractice litigation must be given to individuals providing obstetric care for low-income women.¹⁴

The question remains, however, whether all these attendant costs of medical malpractice really do justify large-scale changes in the tort liability approach. To understand the most significant problems with the liability system, it is necessary to examine the apparatus in some detail and assess the strengths and weaknesses of its component institutions. In the following section, we will analyze the roles played by insurers, lawyers and health care providers in the overall increase in medical malpractice liability costs.

INSTITUTIONAL ANALYSIS

Insurers

Some have accused the insurance industry of creating the malpractice crisis in order to bring about increases in premiums. For instance the president of the Association of Trial Lawyers of America has stated, "the insurance industry itself has created the situation and now seeks to profit from it."¹⁵ Consumer advo-

⁵ Levit and Freeland, "National Medical Care Expenditures," *Health Affairs* (Winter 1988): 124. See also Weiler, *Medical Malpractice* (ALI Background Paper, 1987).

⁶ Premiums are based on claims history of the geographic location and the individual specialty. Since certain specialties are known to lead to many more claims than others, specialty designation has the greatest impact on one's insurance premium. For instance, St. Paul's rates specialties according to eight classes. Family practice, class four, is indexed at 1.0. Physicians who do no surgery, including allergists, dermatologists and psychiatrists, are in class 1A and indexed at .32. On the other hand, neurosurgical physicians are in class eight, and are indexed at 3.48. This means that in a given state, if family practitioners are charged \$10,000 for malpractice premiums, psychiatrists are charged \$3,200 and neurosurgical physicians are charged at least \$35,000. In major metropolitan areas, malpractice premiums are quite a bit higher. For instance, St. Pauls charged class four physicians \$43,900 in California in July of 1989. In Los Angeles, however, those physicians are charged \$53,600. This compares with the \$6,800 St. Pauls charges class four physicians in Arkansas.

⁷ See General Accounting Office, *Medical Malpractice: Insurance Costs* (Washington, D.C. 1986).

⁸ See Florida Academic Task Force, 27.

⁹ See Bovbjerg and Sloan, *Medical Malpractice*.

¹⁰ See AMA, *Trends in Health Care*.

¹¹ See Tancredi and Baroness, "The Problem of Defensive Medicine," *Science* 200 (1978): 879.

¹² See Reynolds, Rizzo, and Gonzalez, "The Cost of Medical Professional Liability," *JAMA* 257 (1987): 2776.

¹³ See Hughes, Rosenbaum, Smith and Fader, "Obstetrical Care for Low-Income Women: The Effects of Medical Malpractice on Community Health Centers, in Institute of Medicine," *Medical Professional Liability in the Delivery of Obstetrical Care*, vol. 2, 59-78.

¹⁴ See Institute of Medicine, *Medical Professional Liability in the Delivery of Obstetrical Care*, vol. 1, (1989): 1-14.

¹⁵ See Perlman, Presidents Page, *Trial*, January 1986, 5.

cates have made much the same charge.¹⁶ That sentiment was reflected in the comment of J.B. Spence, one of the country's leading personal injury attorneys, who stated: "The insurance industry in this country has a gun to the head of the doctors [and t]he doctors in turn have a gun to the head of the legislatures."¹⁷ This same diagnosis was made about the crisis atmosphere surrounding tort law generally in the mid 1980's, and the "reforms" this atmosphere provoked.¹⁸

These accusations seem to have little merit, at least with regard to medical malpractice insurance. To our mind the largest share of the problem is the volatility of the liability insurance line. Insurance companies must rely on the predictability of the legal risk to be able to set their premiums,¹⁹ but predictability is difficult to achieve in malpractice. To price their policies actuaries must try to estimate the frequency (under an "occurrence" policy) or at least the severity (under a "claims made" policy) of suits that will not finally be resolved for a decade or more. During this "long tail," there can be, and have been, substantial changes in patient propensities to sue and jury sentiments regarding awards.²⁰ Aggravating this problem is the insurance cycle—i.e., fluctuations in premiums attributable to changes in investment earnings on revenues, interest rates, the stock market, and the value of the dollar.²¹

By contrast, the collusion hypothesis seems inherently implausible.²² Collusion is rarely seen in an industry that has a comparatively low level of concentration in antitrust terms, as has the insurance industry. Moreover, any cartel formed in the insurance industry would be difficult to maintain, because cartel members can too easily attract business by improving

the terms of coverage at the fixed price. In addition, during the malpractice crisis of the 1970s, and the product and municipality crisis of the 1980s, as big a feature of the problem was a lack of availability of insurance. It seems odd for a cartel to refuse to sell its products at even unduly high prices. Finally, and most importantly for medical malpractice, a substantial portion of this coverage is offered by "bedpan mutuals," insurance companies controlled by the doctors and hospitals themselves.²³ There is no reason to suppose that these carriers would be a part of a scheme to price gouge their own principals. For those several reasons the collusion hypothesis lacks theoretical economic support.

In addition, empirical analysis of long-term insurance premiums and costs supports quite a different di-

²³ The malpractice insurance industry has changed a great deal in the past decade. Physicians in private practice traditionally purchased insurance directly from malpractice insurers. Those physicians who worked for hospitals or Health Maintenance Organization (HMOs) had their malpractice insurance purchased by their employer. Since the late 1970s, however, more and more hospitals have chosen to self-insure rather than buying commercial insurance. Indeed a survey in 1980 indicated that there were already nearly 1,000 hospitals self-insured. See Needleman and Hackbarth, "The Malpractice Insurance System in Obstetrical Care: Recent Experience and Options for Change." Paper prepared for the Institute of Medicine. Washington, D.C. (1988). This self-insurance phenomenon undoubtedly accelerated during the malpractice crisis of the 1980s as all premiums increased dramatically.

Self-insurance is not the only change that has occurred in malpractice underwriting. As noted, before the insurance crisis of the mid-1970s, malpractice insurance for individual physicians was typically provided by commercial insurers. After this malpractice crisis, there was a great deal of consolidation in the market as many insurers withdrew. Medical societies themselves created their own insurance companies. The largest of these, the Medical Liability Mutual Insurance Company of New York, now possesses nearly 40 percent of the New York state market and nearly six percent of the overall national market. See Stern, "Medical Malpractice, Fidelity Insurance." *Bests Review* 89 (1988): 34. Hospital associations also developed insurance companies. The largest of these, the Pennsylvania Hospital Insurance Company, possesses 33 percent of the Pennsylvania hospital malpractice market. These so-called bedpan mutuals are, as one would expect, responsive to providers' input. This does not mean that they will be immune from market forces, or that they will behave differently than other insurers when faced with rising claims rates and increased severity of claims. One would expect, however, that they would be unwilling to act in collusion with other insurers in any effort to raise premiums artificially high.

In certain states, state legislatures had to step in to provide alternatives when the majority of medical malpractice insurers withdrew from the market. Most states created joint underwriting associations (JUAs), which are non-profit pooling arrangements funded initially by all entities providing insurance in a particular state. After the initial capital investment, the JUAs are intended to be self-supporting through physician premiums. At present, 13 states have functioning JUAs, with market shares ranging from three percent in Kansas to 83 percent in Rhode Island in 1986. See Kenney, *Financial Condition of Medical Malpractice JUAs*. (Shalmsberg, Ill.: Alliance of American Insurers) (1987). Since insurance companies can face annual assessments if JUA deficits develop, the insurance industry keeps a close eye on the vitality of JUA programs.

The rest of medical malpractice insurance is offered by commercial insurers. Some insurers, such as the St. Paul's group, offers insurance in many states.

Most malpractice policies are structured in a similar fashion. Medical malpractice insurance policies typically involve both monetary limits on individual claims or occurrences, and aggregate amounts that will be paid over a policy year. In some states, the limits are as low as \$100,000 per occurrence and \$300,000 in aggregate. More typical, is a minimum amount of \$400,000 per occurrence and \$1 million in aggregate, while many states have moved to policies involving \$1 million per occurrence and \$3 million in aggregate. There is very little experience rating in the medical malpractice insurance industry. Hospitals usually have much higher annual limits, ranging between five and thirty million dollars. See Institute of Medicine, *supra* note 15, Volume 1, Chapter 6, Obstetrical Malpractice Insurance.

¹⁶ See Horwitz, "Nader Charges Insurers with Price Gouging," *Washington Post*, January 7, 1986, D1, col. 6.

¹⁷ See J.B. Spence, Testimony Before Academic Task Force for Review of the Insurance and Tort Systems, Vol. 2 at 136 (Miami, Fla., February 3, 1987), cited in Nye, Gifford, Webb, Dewar, "The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances," *Georgetown Law Journal*, 76 (1988): 1495.

¹⁸ See Nader, *The Assault on Injured Victims' Rights*, *Denver University Law Review* 64 (1988): 625.

¹⁹ See generally, Abraham, *Distributing Risk* (1985).

²⁰ George Priest has explored the problems posed for insurance by tort law generally. See Priest, "The Current Insurance Crisis and Modern Tort Law," *Yale Law Journal* 96 (1987): 1521 and Priest, "The Antitrust Suit and the Public Understanding of Insurance," *Tulane Law Review* 63 (1989): 999. Priest's concerns regarding eroding risk pools do not appear to be applicable to malpractice insurers.

²¹ See Abraham, *The Causes of the Insurance Crises in New Directions in Liability Law*, ed. W. Olson (New York: Academy of Political Science 1988).

²² See Priest, "The Current Insurance Crisis," and Priest, "The Public Understanding of Insurance," and most of the articles in the Symposium, Perspectives on the Insurance Crisis, *Yale Journal of Regulation* 5 (1988): 367-516. The case for collusion is made in National Association of Attorneys General, *An Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance*, May, 1986. A group of state attorneys general did file an antitrust suit against major casualty insurers: see *In re Insurance Antitrust Litigation*, 723 F. Supp. 464 (N.D. Cal. 1989). The suit was dismissed on McCarran-Ferguson grounds. See also Ayres and Siegelman, "The Economics of the Insurance Antitrust Suit: Towards an Exclusionary Theory," *Tulane Law Review* 63 (1989): 971.

agnosis.²⁴ In both New York and Florida, careful studies have documented the relationship between premiums and costs in the medical malpractice area. For example, the Florida Academic Task Force found that the primary cause in that state of increased malpractice premiums over the years 1980 to 1988 was the substantial increase in loss payments to claimants. The Task Force also demonstrated that insurance company profits are roughly equivalent to the profits made by other corporations in the United States.²⁵ There appears to be little support, then for the contention that the malpractice crisis was the result of insurance monopoly and excess profits.

Litigation System

The litigation system creates pressure for growth in malpractice premiums when there is either an increase in the number of claims being brought against insured individuals or institutions, or when the average payment on (i.e., the severity of) individual claims rises. Throughout the 1970s and much of the 1980s, both the frequency and severity of claims increased dramatically.²⁶

Overall, between 1975 and 1984, Danzon estimates that there was an average increase of 10 percent per year in claims brought against physicians, and that during the period from 1982 to 1986, the claim frequency per 100 physicians rose from 13.5 to 17.2 per year.²⁷ It appears that claims rates are now back

down to 13/100 physicians per year.²⁸ As one might expect, claims vary a great deal by specialty.²⁹ Overall, however, it appears that somewhat more than one in twenty physicians are sued successfully each year.³⁰

The mean amount paid for each claim is an even more important determinant of the legal cost pressures placed on insurers. There is little doubt that the size of malpractice claims rose a great deal during the 1970s and 1980s. Part of the increase in severity appears due to large jumps in jury verdicts. For example, the average award in jury verdicts jumped from \$200,000 in 1974 to almost \$650,000 in 1984 for malpractice cases in the California Superior Courts.³¹ (To put this in some perspective, we should note that health care costs increased on the order of 60–70% over the same period.) These high jury verdicts induce, in turn, higher settlement amounts. The average malpractice settlement rose from under \$12,000 in 1970 to \$26,000 in 1975, to \$45,000 by 1980, reached \$80,000 by 1984 and topped \$100,000 by 1986.³² As one might expect there is a great deal of variation from state to state in claims severity.³³ For example, the Florida Academic Task Force has emphasized the

²⁸ Physicians and Surgeons Update, 1.

²⁹ The AMA estimates that before 1981, there were 3.2 claims per 100 physicians per year, and that by 1985, the incidence had tripled to 10.1. For obstetrician/gynecologists, the average annual incidence rose from 7.1 per 100 physicians in 1981, to 26.6 by 1985. For all surgeons, the increase was 4.1 in 1981 to 16.5. See *Professional Liability Clearinghouse, American Medical Association Center for Health Policy Research, Professional Liability Update* (Dec. 1986), cited in "Note, The Applicability of Experience Rating to Medical Malpractice Insurance," *Case Western Reserve Law Review* 38 (1987): 255.

³⁰ The best estimates are that nearly 50 percent of all claims result in some sort of compensation for the plaintiff.

³¹ See American Medical Association, *Professional Liability in the 80s, Reports 1, 2 and 3*. (Chicago: AMA, October 1984, November 1984, March 1985.) While increases in California may have been particularly sharp, they are not unrepresentative. The Rand Institute for Civil Justice has developed information on jury verdicts in Chicago and San Francisco for the past twenty years. Their data indicates that awards for malpractice plaintiffs outstripped awards for other high profile tort actions, such as product liability. See Shanley and Peterson, *Comparative Justice: Civil Jury Verdicts in San Francisco and Cook Counties, 1959–1980* (Santa Monica, Calif.: Rand Corporation, 1983), R-3006-ICJ. Other Rand data suggests that the average jury verdict in a malpractice case in these two cities increased from \$50,000–\$100,000 in the early 1960s to \$1.2 million in the early 1980s. See Peterson, *Civil Juries in the 1980s* (Santa Monica, Calif.: Rand Institute for Civil Justice, 1987). In the Miami area, the Florida Academic Task Force reports that jury verdicts on behalf of plaintiffs averaged nearly \$900,000 from 1985 through 1987. See Florida Academic Task Force, 147–50.

³² See Weiler, *Legal Policy for Medical Injuries: The Issues, the Options and the Evidence* (January 1988). Danzon notes that severity increased at double the rate of the Consumer Price Index from 1975 to 1984. See Danzon, "Medical Malpractice" in *Liability*, 105. Bovbjerg and Sloan have estimated that the paid claim severity rose from approximately \$45,000 per claim in 1980 to over \$100,000 per claim in 1986. See Bovbjerg and Sloan, *Medical Malpractice*, 8.

³³ In Arkansas, the average indemnity per paid claim was \$31,000 in 1980 and \$51,000 in 1984. See General Accounting Office, *Six State Studies* (1986). In Florida, on the other hand, the average indemnity was \$80,000 in 1980 and over \$140,000 in 1984. Unlike the frequency of claims, it appears that severity of claims has continued to increase. St. Pauls, for instance, estimates that the cost per claim increased 30 percent from 1982 to 1985. These increases have continued, so that the increase from 1982 to 1988 is nearly 80 percent. See *St. Paul's Physician Update*.

²⁴ The New York figures are contained in the Report of New York State Insurance Department on Medical Malpractice, *A Balanced Prescription for Change* (New York: 1988).

²⁵ See Nye et al., "The Causes of the Medical Malpractice Crisis," 1499. At the same time, the claims made by insurance companies that the malpractice line of insurance is unprofitable have been refuted by reports from the General Accounting Office (GAO). One study by the GAO concluded that profitability estimates for the medical malpractice line of insurance depends primarily on the adequacy of reserves for future payments of claims and the accounting principle used to estimate the value of the reserves. Using its own recommended accounting principles, the GAO determined that for the years 1975 to 1985 the malpractice line was quite profitable (estimated profitability being \$2 billion): See General Accounting Office, *Insurance—Profitability of the Medical Malpractice and General Liability Lines* (Washington, D.C.: July, 1987). Another GAO study showed that of the property/casualty insurance lines that became insolvent from 1969 to 1978, none had medical malpractice as a primary line: see General Accounting Office, *Insurer Failures—Property/Casualty Insurer Insolvencies and State Guaranty Funds* (Washington, D.C.: July, 1987).

²⁶ The following empirical information is drawn from the same sources as were cited in footnote 2. We should note that claims data is notoriously unreliable. As Jacobson remarks "In evaluating these data, some important limitations must be considered. Aside from major gaps in available data, the reported data cannot be compared easily. Each data-reporting system used a different standard for defining the principal allegations of negligence, and each system uses different assumptions and numerical bases for data reporting. Some report data from all claims and expenses (ie, defense costs), including settlements and those in which no indemnity was paid. Others report averages only on a claims-paid basis or by looking at nonzero jury awards alone. Because many of the claims filed result in no indemnity payments, how those are incorporated into the figures makes a major difference in the apparent scope of the problem. One result of these different approaches is that estimates of average verdicts vary widely and statements about averages need to be scrutinized." Jacobson, "Medical Malpractice and the Tort System," *JAMA* 262 (1989): 3322.

²⁷ Danzon, "Medical Malpractice" in *Liability*, 103.

importance of large awards in driving up the overall average severity in Florida.³⁴

These huge claims have a much broader effect than simply dragging up the average cost per claim.³⁵ As noted earlier, they induce a great deal of variation in insurance costs, making it difficult for actuaries to estimate total costs in an insurance market that is as segmented and thin as is malpractice.³⁶

The data regarding rising numbers of claims and severity of claims, combined with the effects of huge jury verdicts or settlements on risk pooling, provide strong evidence that the longer term increase in insurance premiums charged individual physicians and hospitals are a result of real changes in tort costs. The question remains, why have there been these increases in number of claims? Are physicians providing poorer quality care or are patients suing more frequently for other reasons? Research into iatrogenic injury and malpractice litigation can provide some answers to these questions.

Health Care System

Some have conjectured that the increase in claims and severity of claims is simply a matter of potential plaintiffs mining a mother lode of potential claims. Their assumption is that many potentially "litigable" and "compensable" events occur regularly in hospitals, and, in recent years patients are bringing a larger percentage of these cases into the tort process. This hypothesis is supported by the only published empirical study of iatrogenic injury and litigation, conducted in California in 1974.³⁷ The results were

³⁴ In 1975 in Florida, the largest paid claim was \$500,000. In 1979, the largest paid claim was \$600,000 but in 1981, there was a paid claim of \$1.6 million. In 1984, the largest paid claim was over \$5 million. In 1981, there were a total of 16 claims for more than \$500,000 in Florida, while in 1983 there were 57 and in 1984 there were 105. Claims worth more than \$1 million represented 4.9 percent of the total amount of paid claims in 1981, but in 1986 these claims accounted for 29.1 percent of the total compensation paid. See Nye et al., "The Causes of the Medical Malpractice Crisis," 1552. These are not the highest claims in the country. Nor has the huge verdict phenomenon abated. In 1988, the highest personal injury jury verdict in the country was rendered against a hospital in Houston for \$52 million. See *American Bar Association Journal*, July 1989.

³⁵ A few large awards lead to great discrepancies between the median amount paid per claim, the middle number obtained when the claims are arranged in ordinal fashion, and the mean amount paid per claim, the amount calculated by dividing the total indemnity by the number of claims. For instance, in 1984 the General Accounting Office noted that the median claim payments were \$18,000 while the mean claim payments were \$80,000. See General Accounting Office, *Medical Malpractice: Characteristics of Claims Closed in 1984*, 2.

³⁶ See Priest, "The Current Insurance Crisis," 1545.

³⁷ In 1974, the California Medical Association and the California Hospital Association commissioned a study by Don Harper Mills of the incidence of potentially compensable events in hospitals. California Medical Association, *Medical Insurance Feasibility Study* (Sutter Publishing, 1976). This study focused on 23 hospitals which had elected to participate. The researchers analyzed a sample of 20,864 records of inpatients who had been discharged in 1974. They defined a potentially compensable event as a disability that had been caused by health care management. The research team also evaluated

disturbing. The overall rate of potentially compensable events was 4.65 percent;³⁸ the rate of PCE's associated with negligence was .79%.³⁹ Using this data, and combining it with information from the National Association of Insurance Commissioners for 1976 through 1978, Patricia Danzon estimated that in the mid 1970s, less than one out of 10 potentially compensable events associated with negligence gave rise to litigation.⁴⁰

The California study suggests that recent increases in rates of medical malpractice litigation are caused by the fact that more and more litigants are now actually bringing what always were potentially valid claims.⁴¹ Again, though, one must put these statistics about medical negligence in context. Modern health care is an inherently risky enterprise, employing a variety of intrusive procedures, equipment and drugs to combat diseases that would have been left to run their (usually fatal) course a generation ago. But however sophisticated its science and technology, medicine still must rely on the care and attention of doctors, nurses and technicians for the use and safety of these procedures. Unfortunately, like all human beings, medical personnel are prone to occasional oversights and mistakes. But when a usually conscientious surgeon makes a momentary inadvertent slip-up—which is negligence in the eyes of the law—this exposes the patient to severe and irretrievable harm for which a tort suit can be brought.⁴² Thus, it is revealing that

whether or not the potentially compensable event was caused by negligence, and graded each potentially compensable event according to severity.

³⁸ Among these PCEs, 35.7 percent led to minor disability of 30 days or less and did not require surgery. Another 25.7 percent of the PCEs had minor disability that did not exceed 30 days but did require surgery. Major disability, lasting for more than 30 days but less than two years, occurred in 18.6 percent of patients. Another 6.5 percent of PCEs resulted in minor but permanent partial disabilities. 2.2 percent of the PCEs gave rise to major permanent partial disability and another 1.6 percent gave rise to grave permanent disability. Death occurred in 9.7 percent of PCEs.

³⁹ Forty-two percent of the PCEs that proved fatal were associated with negligence, whereas only 11.9 percent of the PCEs leading to temporary disabilities were caused by negligence. The overwhelming majority of PCEs occurred in the operating room (71.8 percent).

⁴⁰ Her estimates suggest that if all cases that could potentially give rise to successful tort litigation did so, there would be 10 times the number of claims and 20 times the number of paid claims. See Danzon, *Medical Malpractice* (Cambridge, Mass.: Harvard University Press, 1985). Danzon has since estimated that at present greater than one in 10, perhaps as many as one in six or seven of potentially compensable events associated with negligence now lead to a claim, largely as a result of the increase in the number of claims over the period from 1975 to 1986. See Danzon, "The Frequency and Severity of Medical Malpractice Claims: New Evidence," *Law and Contemporary Problems*, 49 (1986): 57-84.

⁴¹ Of course, the available empirical information concerning the "mining" hypothesis is limited. First of all, the California study was a non-random sample, suggesting there may be considerable bias in its results. Moreover, little attention was paid during the conduct of the research to methodological issues such as reliability and validity of judgments concerning potentially compensable events or negligence. In addition, Danzon's work was based on a somewhat inadequate database, the National Association of Insurance Commissioners closed-claims data from 1975 through 1978. The Harvard Medical Practice Study Group, of which we are members, has just completed a study in New York, *Patients, Doctors, and Lawyers* (1990), which addressed these concerns: we found that the present gap between negligent injuries and actual tort claims is even starker than the California estimates.

⁴² See generally Grady, "Why Are People Negligent? Technology, Nondurable Precautions and the Medical Malpractice Explosion," *Northwestern University Law Review* 82 (1988): 293.

since the mid 1970's there has been the same percentage increase in malpractice claims and costs in Canada and Great Britain (though from a much lower base level than the United States), despite their very different organization and financing of both legal and health care.⁴³

But whatever the explanation, the fact is there is no evidence we have been experiencing too many malpractice claims; if anything there appear to be too few. It would seem unfair, then, to encumber even further access to the tort system by those injured individuals with valid claims. On the other hand, large awards tend to have an unsettling effect on the insurance system. The erratic nature of awards, especially their pain and suffering component, produces unduly volatile premium changes during "crisis" periods and dislocation in the lives of individual practitioners, whether sued successfully or not.

RESPONSE—PUBLIC POLICY

In response to the pressure of rising malpractice litigation and premiums, all the state legislatures have sought to reform at least some of their law concerning malpractice liability. During the 1970's and 1980s, this effort took the form of "conventional" tort reform, under which the legislatures tinkered with different tort doctrines and procedures for malpractice claims. In the last few years, though, one finds growing interest in moving beyond tort law altogether, whether into administrative fault or no-fault compensation systems. We will first review conventional tort reform and then sketch some of the suggested alternatives to traditional tort litigation.

Conventional Tort Reform

A variety of types of conventional tort reform have been instituted by state governments in the last two decades, most fashioned in response to the first malpractice crisis of the mid 1970s. These statutory changes, designed to reduce the frequency and severity of malpractice claims and premiums, are aimed at one of three targets: initial access of patients to the courts, chances of success in establishing liability, and the potential amount of damages awarded. Since most of these reforms were instituted in at least some states more than a decade ago, sufficient time has elapsed to

allow empirical evaluation of the impact of such measures.

We start with changes in liability rules, since this is perhaps the most distinctive feature of malpractice law. Unlike product liability law, courts have stuck closely to the fault principle, as reflected in the rule that only deviation from customary medical practice will suffice for liability. Few courts have strayed from this central assumption;⁴⁴ nor have any legislatures relaxed it. However, a number of statutory enactments in the 1970s did modify the detailed rules embodying the fault principle, with a view to rolling back some of the common-law doctrines developed by judges in previous decades to make it easier for patients to establish physician fault. For instance, the judges had largely overturned the old locality doctrine under which practitioners were held only to the standard of practice in their same locale. Since 1970, approximately one dozen state legislatures have restated the standard of care by reference to local practice.⁴⁵

Another such effort sought to limit the operation of the doctrine of *res ipsa loquitur*. This judicial doctrine made it somewhat easier for patients to get a malpractice case to a jury in situations where an apparent mishap had led to a poor outcome. Yet another legislative attempt to overcome judge-made law concerned informed consent. In the 1960s and 1970s, some courts had defined the standard of informed consent in terms of what a reasonable patient needed to know, rather than what a reasonable physician felt it necessary to disclose. A number of state legislatures in turn explicitly enacted the reasonable practitioner standard.⁴⁶

A more thoroughgoing method for changing liability standards would be to specify that practice guidelines developed by physicians should act as definitions of the standard of care for courts. Using outcome studies⁴⁷ and consensus panel determinations of practice standards,⁴⁸ health services researchers have begun to develop clinical parameters to determine appropriate care.⁴⁹ For instance, the American College of Physicians and Blue Cross/Blue Shield have developed a series of guidelines for common diagnostic

⁴⁴ The most notable being *Helling v. Carey*, 519 P.2d 981 (Wash. 1974).

⁴⁵ See Robinson, "The Medical Malpractice Crisis of the 1970s: A Retrospective," *Law and Contemporary Problems* 49 (Spring, 1986): 6.

⁴⁶ See Meisel and Kabnick, "Informed Consent to Medical Treatment: An Analysis of Recent Legislation," *University of Pittsburgh Law Review* 41 (1980): 407.

⁴⁷ See Wennberg, Mulley, Hanley et al., "An Assessment of Prostatectomy for a Benign Urinary Tract Obstruction: Geographic Variations in the Evaluation of Medical Outcomes," *JAMA* 259 (1988): 3027.

⁴⁸ See Kahn, Kosecoff, Chassin, et al., "The Use and Misuse of Upper Gastrointestinal Endoscopy," *Annals of Internal Medicine* 109 (1988): 664-70.

⁴⁹ See Brook, "Practice Guidelines and Practicing Medicine: Are They Compatible?" *JAMA* 262 (1989): 3027.

⁴³ See Dewees, Coyte and Trebilcock, *Canadian Medical Malpractice Liability: An Empirical Analysis of Recent Trends* (1989); Ham, Dingwall, Fenn and Harris, *Medical Negligence: Compensation and Accountability*, (1988): 11-12 (on the United Kingdom).

tests.⁵⁰ While some may question the validity of such parameters⁵¹ it seems likely that development of medical practice algorithms will accelerate. Indeed, recent legislation creates new opportunities for research on and development of, these methods,⁵² and this Commission has recommended as part of a national system of quality assurance that national practice guidelines and standards of care be developed in a newly created agency for Health Care Policy and Research.

Similar practice guidelines could also be used to determine the standard of care for malpractice proceedings. However, their development is a very complicated and lengthy process. Therefore, while we now see the first uses of such guidelines in an effort to improve care and decrease litigation,⁵³ it is doubtful they will play a major role in the near future.

Another set of tort reforms placed a variety of restrictions on what was perceived as too easy access to common law courts.⁵⁴ One way to do this was to shrink the statutory limitation period. Using a judge fashioned discovery doctrine, many state courts interpreted their statute of limitations as not being tolled until a victim had, or should have, discovered that his injury was a result of doctor negligence. This innovation tended to give plaintiffs a much broader time span in which to file their suit. In response, a number of states repealed the discovery rule or required that claims be brought within a so-called statute of repose that set an outer bound to the discovery principle.⁵⁵ The rationale is that doctors and their insurers should enjoy some protection against litigation launched long after the original treatment, when there is considerable risk that the events will be appraised in light of quite different legal and medical norms than could fairly have been anticipated at the time.

Another such access rule was the limitation of attorney's fees. Plaintiff attorneys take malpractice cases on the basis of a contingent fee, meaning that if and only if the plaintiff wins, the lawyer takes his compensation as a percentage of the award. In response to physicians' concerns about the incentives this arrangement created for malpractice suits, many jurisdictions restricted the size of attorneys' fees, typically by im-

posing a flat percentage or by constructing a sliding scale based on the size of the award. For a time, Florida even experimented with the Anglo-Canadian rule of awarding fees to the prevailing party, but this law was replaced by a sliding scale based on timing of settlement and size of award.⁵⁶

Yet another way to limit access was to institute screening panels. Screening panels are composed of doctors and lawyers who review a case and evaluate its merits before a claim is filed. These screening panels are intended to decrease access to the legal system by influencing parties' evaluations of their probability of success in courts. While many states adopted screening panels in the mid-1970s, there has been less enthusiasm for them in the 1980s, largely because the panels have had little impact except to prolong the length of time and costs before resolution of a suit.⁵⁷

Finally, state legislatures have experimented with limits on damages, again in an effort to moderate the number and severity of claims. One such measure is periodic rather than lump sum payment of large damage awards: this allows the court to adjust the award to subsequent changes in health status of the victim. Another way to restrain damage awards is to reverse the collateral source rule, under which the courts traditionally held that damages payable by culpable defendants should not be reduced even if the patient's loss has been compensated by other sources, such as health or disability insurance.⁵⁸ Numerous states have responded to the arguments that this is a form of "double dipping," either by allowing defendants to introduce evidence concerning sources of compensation such as health and disability insurance, or even mandating that the courts deduct any such collateral insurance payments from tort awards. Of course, offsetting such collateral sources can reduce the deterrent threat of litigation, given that physicians would have a reduced responsibility for the social costs of medical injuries and personal injury lawyers whose fees are a percentage of the total damage award would have less inclination to pursue claims on behalf of a well insured individual, even when the care the individual received may have been grossly substandard.

⁵⁰ See Sox, "Guidelines for Medical Practice: Necessary But Not Sufficient," *Journal of General Internal Medicine* 6 (1989): 551.

⁵¹ See Alper, "ACP Guidelines for Common Diagnostic Tests in the Practicing Internist," *Journal of General Internal Medicine* 6 (1989): 548.

⁵² See Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, sec. 6103.

⁵³ Berwick, "Continuous Improvement as an Ideal in Health Care," *New England Journal of Medicine* 320 (1989): 53.

⁵⁴ See Bovbjerg, "Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card," *University of California at Davis Law Review* 22 (1989): 499.

⁵⁵ See McGovern, "The Variety, Policy and Constitutionality of Product Liability Statutes of Repose," *American University Law Review* 30 (1981): 579.

⁵⁶ See Hawkes, "The Second Reformation: Florida's Medical Malpractice Law," *Florida State Law Review* 13 (1985): 747.

⁵⁷ See Danzon and Lillard, "Settlement out of Court: The Disposition of Medical Malpractice Claims," *Journal of Legal Studies* 12 (1983): 373-4; Shmanske and Stevens, "The Performance of Medical Malpractice Review Panels," *Journal of Health Politics, Policy and Law* 11 (1986): 525.

⁵⁸ See generally Mocerri and Messini, "The Collateral Source Rule in Personal Injury Litigation," *Gonzaga Law Review* 7 (1972): 310. Although it has attracted little attention from state legislatures, the concept of scheduling damages gained some scholarly support as a method for rationalizing the damage determination process: see Danzon, "Tort Reform and the Role of Government in Insurance Markets," *Journal of Legal Studies* 13 (1984): 527-30.

The most straightforward form of damages restriction is the damage cap. As mentioned above, a relatively small number of large awards comprise a substantial share of the total amount of money paid in tort claims. Since the mid 1970s, states have experimented with caps on damages. Some states place numerical limitations on pain and suffering. In the 1970s, most of these numerical restrictions applied to both economic and non-economic damages,⁵⁹ but in the 1980s almost all have focused simply on pain and suffering. To this point only a handful of states have indexed or adjusted their nominal dollar caps to subsequent changes in wage and price levels.⁶⁰

The efficacy of various tort reforms have been assessed by economists and health policy analysts using econometric methods.⁶¹ Danzon, for example, traced the effect of mid-1970s legislation over an extended period of time and updated her research with claims information as late as 1984. She demonstrated that reductions in the statute of limitations result in a significant decrease in claims frequency. Moreover, the reversal of a collateral source rule reduced claims severity by somewhere between 11 and 19 percent, and claims frequency by around 14 percent. Finally, caps on damage awards reduced claims severity by 23 percent, but did not seem to have any effect on the propensity to initiate claims.

In a more recent study, Sloan and co-authors combined data on individual closed claims from the National Association of Insurance Commissioners' *Study of Closed Claims From 1975-1978* with closed claims information from 1984 collected by the General Accounting Office of the United States Congress, and analyzed the effect of tort reforms on claims' severity.⁶² Just as did Danzon, Sloan *et al.* found few tort

reforms that reduced the amount paid per claim. However, damage caps on the total awards, and even caps on just pain and suffering, substantially lowered the amounts paid. As well, changes in the collateral source rule produced sizable reductions in average payments. Laws that encouraged arbitration decreased the amount paid per claim, while changes in the statute of limitations reduced the likelihood that a claim would be closed with payment but did not affect the overall amount per paid claim. All the other reforms had little statistically significant impact.

Several conclusions can be drawn from these studies. First, it appears that changes in liability rules have little effect: malpractice litigation remains fault-based at its core and legislative tinkering changes this very little. Statutory obstacles to access also seem to have little effect, with the exception of changes in statutes of limitations. However, alterations in damage rules—i.e., caps or collateral source offsets—do have a significant effect on both the severity of claims or even the number of claims brought.

As one might have gathered from this review of the content of malpractice reform, most of these measures have been proposed by medical associations and championed by their legislative supporters. However, when a state legislature enacts a tort reform package, the legal dialogue does not end there. Patients and their attorneys can return to the state courts for decisions about how to treat the new statutory law—in particular, under the state constitution. After a decade of such constitutional challenges, it appears that patients have fared quite well in the judicial forum, with many of the state courts having struck down some the key reforms, especially in the damages area.⁶³

Malpractice reform bills can be attacked under both the federal and various states' constitutions. Under the Federal Constitution, courts have largely rejected equal protection, due process and Seventh Amendment challenges.⁶⁴ State courts have been much less deferential in their constitutional scrutiny of malpractice legislation. As part of a general resurgence of state constitutional activism,⁶⁵ state judges have been

⁵⁹ See e.g., Indiana Code Annotated, Section 16-9.5-2-2.1 (Burn's Supplement 1986).

⁶⁰ We have reviewed the major forms of tort reform in the 1970s and 1980s, but our list is not exhaustive. For instance, Bovbjerg's review of tort reforms touches on arbitration as an effort to limit the number of suits getting into court, restrictions of ad damnum clauses as a method for decreasing the size of recovery; expert witness standards as means of increasing the plaintiff's difficulty or cost of winning; and precalendar conference requirements and preferred scheduling for malpractice cases as means of decreasing the costs of the judicial process. See generally Bovbjerg, "Legislation on Medical Malpractice," 499.

⁶¹ The most recent of these empirical analyses are Danzon, "The Frequency and Severity of Medical Malpractice Claims: New Evidence," *Law and Contemporary Problems* 49 (1986): 37-56; and Sloan, Mergenhagen and Bovbjerg, "Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis," forthcoming, *Journal of Health Policy, Politics, and Law*. Unless otherwise stated we rely on these authors' analyses. This is not to overlook some of the important research which was done before 1985. See, in particular Reder, "An Economic Analysis of Medical Malpractice," *Journal of Legal Studies* 5 (1976): 267; Feldman, "The Determinants of Medical Malpractice Incidence: Theory of Contingency Fees and Empirical Evidence," *Atlantic Economic Journal* 7 (1979): 59; Danzon, "The Frequency and Severity of Medical Malpractice Claims," *Journal of Law and Economics* 27 (1984): 115; Adams and Zuckerman, "Variations in the Growth and Incidence of Medical Malpractice Claims," *Journal of Health Politics, Policy and Law* 9 (1984): 475; Sloan, "State Responses to the Malpractice Insurance Crisis of the 1970s: An Empirical Analysis," *Journal of Health Politics, Policy and Law* 9 (1985): 629.

⁶² See Sloan, Mergenhagen and Bovbjerg, "Effects of Tort Reform."

⁶³ See in general, Vinson, "Constitutional Stumbling Blocks to Legislative Tort Reform," *Florida State Law Review* 15 (1987): 31; Turkington, "Constitutional Limitations on Tort Reform," *Villanova Law Review* 32 (1987): 1299; Smith, "Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws," *Oklahoma Law Review* 38 (1985): 195; Learner, "Restrictive Medical Malpractice Compensation Schemes: A Constitutional quid pro quo Analysis to Safeguard Individual Liberties," *Harvard Journal on Legislation* 18 (1981): 143.

⁶⁴ See e.g., *Fein v. Permanente*, 695 P. 2d 665, 38 Cal. 3d 137, 211 Cal. Rptr. 368 (1985), appeal dismissed, 106 S.Ct. 214 (1986).

⁶⁵ See Brennan, "The Bill of Rights in the States: The Revival of State Constitutions as Guardians of Individual Rights," *New York University Law Review* 61 (1986): 535.

especially offended when they perceive physician groups having secured statutory measures that substantially cut back on the tort rights of injured patients without the latter receiving some form of *quid pro quo* along the lines of no-fault workers' compensation. That judicial sentiment has been displayed in a number of constitutional guises; in the 1970s usually under equal protection or due process, but in the 1980s more often under the right of access to the court or to a jury trial.⁶⁶

It is no accident that this judicial sentiment tends to surface in challenges to the constitutionality of restrictions on tort damages. While these are the measures that do offer the greatest relief to doctors from the burden of the malpractice regime, the cases where the caps are applied often involve the most seriously injured patients, and in situations where judges realize that some of the supposedly "excess" award is really going to pay the percentage contingent fee of the attorney whose services were necessary to secure any tort recovery for the injured party. In addition, as we have seen, the conclusion of more systematic research is that under the common law system, there are far fewer malpractice claims being made (let alone paid) in the legal system than there are malpractice events and injuries occurring in the health system.

One other alternative for overcoming the deficiencies of the present system might be to move from a tort to a contract regime. Some have argued that tort law smacks too much of "command and control" regulation, and thus retards the efficiencies and innovation that could arise out of a "free market" approach.⁶⁷ They advocate much broader scope for voluntarily-negotiated contracts between patients and providers which would stipulate whether and how much compensation should be paid for injuries occurring in the course of therapy. In theory, these contractual alternatives would be more efficient in reflecting the mutual interests of the immediate parties while reducing the administrative costs associated with litigation. For example, providers and patients could stipulate that in the event of injury due to substandard care, certain scheduled damages would be available. The definition of substandard care in this case could be left up to binding arbitration which was faster and cheaper than jury trials.

⁶⁶ *Smith v. Department of Insurance*, 507 So.2d 1080 (Fla. 1987); *Kansas Malpractice Victims v. Bell*, 757 P.2d 251 (Kan. 1988); *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988); *Sofie v. Fibreboard Corp.*, 771 P. 2d 711 (Wash. 1989). In *Boyd v. Bulala*, 647 F.Supp. 781, 786 (W.D. Va. 1986) a federal district court held that legislation violated both the federal and Virginia's guarantee of a jury trial, but that state law interpretation was reversed in *Etheridge v. Medical Center Hospital*, 376 S.E. 2d 525 (Va. 1989), and in *Boyd v. Bulala*, 872 F.2d 119 (4th Cir. 1989), regarding the federal constitution.

⁶⁷ See generally, Havighurst, "Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles," *Law and Contemporary Problems* 49 (1986): 143.

Of course, there are drawbacks associated with contractual arrangements of this sort. The contracts themselves could be the subject of a good deal of litigation, decreasing the potential gains in efficiency. More important, both state courts and state legislatures have exhibited great concern about the likely fairness of the terms of a contract struck between a provider and a patient, given the inequalities in bargaining power and knowledge that exist between these parties.⁶⁸ Thus while contractual alternatives to malpractice litigation do represent another option that should be explored, they are clearly not a panacea for the problem of medical injury.

Beyond Tort Law

The reforms we have suggested for tort law might go some distance in terms of rationalizing the system. However, we are still left with the overwhelming empirical facts that few negligent adverse events now lead to claims, and conversely that many claims arise out of situations in which there is no evidence of negligence or even of injury. There are both too many unwarranted claims, and too many appropriate claims that are never brought. Any comprehensive review of the medical malpractice crisis must at least consider what options lie beyond tort litigation.

The tort reforms discussed in the previous section modify the rights and obligations of patients and doctors in malpractice litigation. They do not, however, change the basic ground rules—that the patient must prove to a jury that he or she was injured due to the negligence of a physician or health care provider. There are, however, numerous alternatives to traditional tort litigation, some modest, some major. In this section we review several such methods through which one might provide compensation to patients injured as a result of their medical care, and also create incentives for better care by providers.

Alternative Dispute Resolution—Given the high administrative as well as emotional costs of litigation, many have sought alternative dispute resolution formats for medical malpractice claims. The term "alternative dispute resolution" is an umbrella concept covering a variety of specific procedures designed to provide fair outcomes at lower costs. Included in ADR are such approaches as arbitration, or mediation.⁶⁹ In the area of medical malpractice, the most prominent vehicle has been the pretreatment agreement through which patients accept binding arbitra-

⁶⁸ Havighurst, "Private Reform of Tort-Law Dogma," 163-4.

⁶⁹ See Goldberg, Green, and Sander, *Dispute Resolution*, (Boston: Little Brown and Company, 1985).

tion in lieu of a jury trial, an agreement that is made enforceable by legislation.⁷⁰ If a patient is injured, and seeks compensation, the determination of liability and the amount of damages is made by a neutral arbitrator rather than a court. Since the process of arbitration is streamlined, there are comparatively less administrative costs than in traditional litigation.

Courts generally have found this arbitration model acceptable.⁷¹ They have, however, carefully scrutinized the terms of the initial agreement and the circumstances of its signing in order to ensure that there was a fully informed and voluntary waiver of the patient's right to a jury trial.⁷² Such judicial scrutiny has largely dissipated the possible gains from arbitration as a more expeditious and economic procedure. In turn, this may explain why econometric analyses noted above have shown little impact of arbitration models on changes in the number of claims or severity of claims.⁷³ Thus, while further experimentation in dispute resolution procedures might be appropriate for the benefit secured in individual cases, binding arbitration does not appear to offer huge potential as an alternative to tort litigation.

Administrative Fault—The administrative fault system advocated by the American Medical Association is a more serious attempt at ADR, because this program relies not on ad hoc agreements and adjudication, but on a new specialized tribunal that would be responsible for resolving all malpractice claims, while retaining fault as the basis for liability.⁷⁴ Specifically, the proposal contemplates the establishment of a state agency called the "Medical Practices Review Board." The review board would adjudicate medical liability disputes, investigate substandard care by physicians, undertake disciplinary proceedings, and act as a source of information concerning performance by licensed physicians.⁷⁵

Under this plan, malpractice claims would be removed from the civil justice system and placed before this administrative board for determination.⁷⁶ Either

party could then appeal the Board's decision to an intermediate appellate court in the state. The AMA proposal also calls for a number of changes in substantive medical liability law.⁷⁷ In an effort to provide some quid pro quo for patients and thus survive constitutional challenge in the state courts, the AMA proposal contemplates broad powers for the Medical Practices Review Board in credentialing and disciplining physicians.⁷⁸

The administrative fault-based proposal is an attempt to develop an integrated approach to both compensation for past medical injuries and deterrence of substandard practice in the future. There are, however, some concerns. First, the proposal does face a real constitutional difficulty, because while fault is retained as the basis for liability, the jury is eliminated entirely. If state courts are already striking down caps on tort damages as offensive to the right of access to the courts and juries, they will be very skeptical about the validity of the AMA proposal. Next, while many have advocated increased efforts by state disciplinary panels,⁷⁹ it is not at all clear that the best efforts of such boards will result in significant deterrence signals.⁸⁰ Probably in partial recognition of

board personnel and, if it appeared to have merit, would be reviewed by a peer expert. If both the claims reviewer and peer expert felt that the claim had some merit, an attorney on the board's staff would represent the injured claimant. If the claim was felt to be without merit, the patient could still pursue the dismissed claim with a private attorney.

In the hearing stage, an examiner, acting like an administrative law judge in the Social Security system, would preside in a judicial hearing. Prior to the hearing, both patient and health care provider would be required to submit blind settlement offers. The parties would be subject to sanctions if the outcome of the case did not represent a significant improvement over the settlement offer rejected at this stage. At the hearing itself, certain evidentiary rules would be in place, but the judge would be able to play an active role and could call independent experts if she saw fit.

The hearing examiner's decision could be appealed to the Board. A panel of three members of the Board, only one of whom could be a physician, would hear an appeal. No new factual determinations would be made at this stage. For all legal issues, however, the panel would conduct de novo review.

⁷⁷ The AMA envisions some changes in the standard of care which, while not embracing the traditional locality rule, do acknowledge the role that the availability or unavailability of specialized equipment and personnel can play in treatment decisions. Another important change concerns causation. The proposal calls for abandonment of the more probable than not threshold for a finding of causation and allows liability if providers' negligence was a contributing factor. In these cases, damages would be apportioned according to a pure comparative negligence standard. With regard to informed consent, the AMA would adopt the reasonable patient standard. The proposal also opposes lump sum damage claims. In addition, it would cap non-economic damages by an amount tied to the percentage of the average annual wage in the state. Joint and several liability would be eliminated from medical negligence claims. A periodic payment schedule would be put into place and the collateral source rule would be overturned.

⁷⁸ First, hospitals would be required to review physician performances on a regular basis and physicians who are not affiliated with institutions would be required to participate in a credentialing process undertaken by the state. The board would also maintain a clearing-house for information regarding physician discipline and sub-standard care. The board would also have authority to conduct on site review of physicians' practices. Broad powers for disciplining physicians would be lodged with the board. See generally American Medical Association/Specialty Society Medical Liability Project, *Model Medical Liability and Patient Protection Act* (May 1989).

⁷⁹ See Wolfe, Bergman, and Silver, *Medical Malpractice: The Need for Disciplinary Reform not Tort Reform* (1986).

⁸⁰ See Kusserow, Handley and Yessian, "An Overview of State Medical Discipline," *JAMA* 257 (1987): 820. Recently, several large states including

⁷⁰ As of 1987, 15 states had in place such statutes. See Henderson, "Agreements Changing the Forum for Resolving Malpractice Claims," *Law and Contemporary Problems* 49 (1986): 243.

⁷¹ *Madden v. Kaiser Foundation Hospital*, 552 P.2d 1178 (Cal. 1976); *Morris v. Metriyakool*, 344 N.W.2d 736 (Mich. 1984).

⁷² See Bedikian, "Medical Malpractice Arbitration Act: Michigan's Experience with Arbitration," *American Journal of Law and Medicine* 10 (1984): 42.

⁷³ See pages 48-49.

⁷⁴ See Johnson, Phillips, Orentlicher, and Hatlie, "A Fault Based Administrative Alternative for Resolving Medical Malpractice Claims," *Vanderbilt Law Review* 42 (1989): 1366.

⁷⁵ The board would be composed of seven people, each serving a term of five years. At least two, but not more than three, of the members of the board would be physicians. One or more would be consumer representatives. The board itself would appoint the other key personnel in the agency, including attorneys, claims reviewers and investigators.

⁷⁶ The claims resolution process would be divided into four stages. First, there would be a pre-hearing in which an individual who contended that he or she was injured as a result of inadequate health care would initiate the claims process by filling out a simple form. The form would be reviewed by

these potential drawbacks, the American Medical Association has prudently suggested that its plan be initiated in a few states on an experimental basis. This experimental period would also allow some assessment of the ways in which administrative fault either ameliorates or exacerbates the problems with peer review at the hospital level.

Organizational Liability—Another possible alternative to traditional malpractice litigation is to relieve physicians of the direct financial burden of malpractice insurance by shifting the focus of legal liability from individual physician to the hospital or health care institution connected with the incident. Organizational liability is consistent with a number of doctrinal developments in tort litigation that have expanded the “corporate” or “vicarious” liability of hospitals for the negligence of non-employee physicians.⁸¹ It also reflects some new insurance “channeling” arrangements wherein large hospitals provide their associated physicians with coverage under the institutions’ own policy.

These changes in malpractice law and insurance approaches recognize that the hospital is better able to assess its risks and to distribute the burden of its liability across a broad pool of constituents, and thereby obviate the problems faced by individual physicians in the high risk sectors in obtaining insurance at reasonable cost. Even more attractive about this arrangement are the new incentives and opportunities it creates for institutional quality assurance. Because hospitals are much more likely to have their malpractice premiums set according to their claims experience, this new focus of liability would considerably sharpen the deterrence incentive created by malpractice litigation. The hospital also has the institutional perspective and capacity to develop comprehensive standards and procedures that promote quality assur-

ance and safety,⁸² akin to a “systems” approach⁸³ that would lessen the individual finger pointing that makes medical malpractice so emotionally destructive for providers.

There are, of course, problems with organizational liability. First, some would question whether it is equitable to make such hospital liability mandatory and exclusive. They would argue that legal insulation of the physician from liability would decrease deterrence incentives. In addition, there would be a financial problem in the legal shift to organizational liability as hospitals and other health care institutions were saddled with much larger liability insurance premiums, while physicians would no longer have to pay such premiums. Unquestionably, shifts in health care reimbursement schedules would have to accompany any such move to organizational liability. In addition, small hospitals would have to aggregate their risk pools with other hospitals in order to function under organizational liability.

Finally, most physicians are not employed by hospitals and typically they have jealously guarded their professional autonomy, and their relations with patients, against control by hospital administrators. On the other hand, the fact is that doctors already face growing scrutiny from judges and juries in malpractice litigation and recently many state legislatures have been directing hospitals to create quality assurance programs that contemplate ongoing review of individual physicians’ practice decisions and patterns, in order to ensure safer and better care for patients. Thus, doctors are increasingly subject to the kind of supervision contemplated by organizational liability, without having the benefit of any relief for the costs of malpractice insurance.

Ironically, this expansion of quality assurance activities in an effort to reduce the need for and incidence of malpractice litigation by patients has in turn precipitated yet another bout of litigation, this time by affected doctors. The ultimate source of the medical staff’s ability to secure and enforce a higher quality of care in the hospital is the peer review committees’ power to suspend or revoke the credentials of those incumbent doctors who have provided sub-standard

California, New York, Massachusetts and Florida have undertaken sweeping reforms in their state medical disciplinary apparatus. While it is too early to judge in any final way the efficacy of such reforms, it appears that reviewing agencies may have difficulty gaining access to appropriate information regarding quality of care. See Keidan, *Physician Discipline: Cure for the Medical Malpractice Crisis?* (unpublished manuscript 1989) (on file with authors). These agencies are also especially sensitive to the vagaries of state funding and have had difficulty maintaining continuous employment of qualified investigators and lawyers. Thus, if the state’s commitment to such disciplinary panels is not strong, especially in a fiscal sense, deterrence under an administrative fault plan could be weakened significantly.

⁸¹ See Southwick, “Hospital Liability: Two Theories Have Been Merged,” *Journal of Legal Medicine* 4 (1983): 1; and for recent reviews of the cases, see *Jackson v. Power*, 743 P.2d 1376 (Alaska 1987); *Insinga v. Labella*, 543 So.2d 209 (Fla. 1989).

⁸² As mentioned previously, changes in liability standards have increased incentives for physicians to develop appropriate practice standards. For example, in a major risk management effort, the Department of Anesthesia at Harvard Medical School devised specific detailed and mandatory standards for minimal patient monitoring during anesthesia. Such standards had not existed previously but were accepted by practitioners. See Eichhorn, Cooper and Cullen, “Standards for Patient Monitoring During Anesthesia at Harvard Medical School,” *JAMA* 256 (1986): 1017-1020. These practice standards appeared to have lowered malpractice claims against anesthesiologists at participating institutions and efforts are now underway to develop similar standards for obstetricians at Harvard Medical School.

⁸³ Berwick, “Continuous Improvement,” 53.

care in the hospital, and to deny hospital staff privileges to applicants who have shown evidence of poor quality elsewhere. Such decisions to suspend or deny practice credentials can be quite controversial, and lead to litigation on a variety of fronts.

First, physicians who have suffered suspension of credentials may claim that their due process rights were not respected, especially in cases involving public hospitals.⁸⁴ Alternatively, physicians may seek rights of cross examination and other trappings of adjudicative process.⁸⁵ More importantly, physicians who lose their practice privileges may allege antitrust violations: the aggrieved physician will claim that the decision to suspend privileges was not motivated by concerns about quality of care, but rather was an attempt to curb competition in the specialty area.⁸⁶ Indeed peer review activities are now drawing considerable antitrust scrutiny, a trend that will likely accelerate in light of a recent Supreme Court decision.⁸⁷ Yet another concern of physicians who serve on peer review committees is the threat of involvement in malpractice litigation. Since these committees often pass judgment on specific incidents involving physicians on the medical staff, their activities are of special interest to plaintiffs' attorneys who would like access to peer review committee documents. While most states provide explicit immunity for peer review activities, some state courts have managed to find exceptions to these statutes in order to allow discovery of the peer review data.⁸⁸ Such judicial decisions

appear to be influenced by the facts of the individual case, rather than the specific structure of the state immunity laws.⁸⁹ Concerns about the confidentiality of peer review will likely continue to be an area of active litigation in the 1990s, especially as more states pass laws encouraging organizational peer review and quality assurance activities, and require that some of this data be turned over to the state for regulatory purposes.⁹⁰

These various types of litigation create serious concerns on the part of physicians involved in peer review. Even those physicians who recognize that the best long-term response to malpractice litigation is better quality medical practice, and that a physician's peers are better judges of medical care than lawyers or juries, are hesitant to become involved in peer review activities that may lead to litigation. While this is and will continue to be a significant problem even in the present system of tort litigation, it would become even more prominent if one moved to general organizational liability of hospitals. Thus, any comprehensive effort to address medical malpractice litigation must also address the legal problems raised by peer review activities.

No-Fault Patient Compensation—The drawbacks of both traditional tort litigation and of those alternatives that still rely on determinations of fault have led a number of people to advocate "no fault" approaches to medical injury compensation. As far back as the early 1970s, a number of scholars were proposing partial or complete no-fault systems.⁹¹ The partial no fault approaches center on accelerated compensation for designated injuries that are quite likely to be avoidable.⁹² These particular injuries would be extracted from the tort regime and be compensated administratively. Medical adversity insurance differs from pure no-fault or social insurance in that the providers of care remain responsible for paying for the listed outcomes—a form of "strict liability" through provider-purchased, experience-rated casualty insurance. More recently, proponents have been able to draw on the experience of New Zealand⁹³ and

⁸⁴ See *Richardson v. St. Johns Mercy Hospital*, 674 S.W.2d 200 (Mo.App.1984).

⁸⁵ See *Rao v. St. Elizabeth's Hospital*, 488 N.E.2d 685 (Ill.App. 5 Dist. 1986).

⁸⁶ It seems likely that there will be more antitrust litigation in the future. Since 1975, with the decision of *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), the Supreme Court has indicated that the practice of the learned professions will be considered commerce, and thus subject to the scrutiny of the antitrust laws. The initial Supreme Court cases regarding health care antitrust concerned efforts to remove anticompetitive rules which had been put in place by insurers and providers. See *Union Labor Life Insurance Company v. Pireno*, 458 U.S. 119 (1981); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1981). Soon however, aggrieved individuals began to request antitrust scrutiny regarding the behavior of individual hospitals or physicians. See *Jefferson Parish Hospital District #2 v. Hyde*, 466 U.S. 2 (1984); *Weiss v. York Hospital*, 745 F.2d 786 (3rd Cir. 1984).

⁸⁷ See *Patrick v. Burget*, 108 S.Ct. 1658 (1988). With the decision of *Patrick v. Burget*, the Supreme Court indicated that the state action doctrine would not immunize state-required peer review activities by private hospital staffs from antitrust litigation unless states provided official review of such private decisions. Although the Health Care Quality Improvement Act of 1986 was intended to limit antitrust litigation regarding peer review, many observers doubt that it will have this effect. See e.g. Colantonio, "The Health Care Quality Improvement Act of 1986 and its Impact on Hospital Law," *West Virginia Law Review* 91 (1988): 91; Blumstein and Sloan, "Antitrust in Hospital Peer Review," *Law and Contemporary Problems* 51 (1988): 7. Thus we can expect continued antitrust scrutiny of peer review activities. See *Bolt v. Halifax Hospital Medical Center*, 851 F.2d 1273 (11th Circuit), vacated and petition for rehearing en banc granted, 861 F.2d 1233 (11th Cir. 1988), reinstated in part and vacated in part en banc, 874 F.2d 755 (11th Cir. 1989). Lawyers have had some doubts about bringing antitrust suits in this area, and since the major Supreme Court decision is so recent, it is difficult to predict the amount of litigation that will occur in the future. Nonetheless, the *Patrick* decision can only serve as a litigation incentive.

⁸⁸ See *Kalish v. Mt. Sinai Hospital*, 270 N.W. 2d 783 (Minn. 1978).

⁸⁹ Compare *Coburn v. Seda*, 677 P.2d 173 (1984), with *Chandra v. Sprinkle*, 678 S.W.2d 804 (Mo. 1984).

⁹⁰ See e.g. *Beth Israel Hospital Association v. The Board of Registration in Medicine*, 515 N.E.2d 574 (Mass. 1987).

⁹¹ See Havighurst and Tancredi, "Medical Adversity Insurance, a No-Fault to Medical Malpractice and Quality Assurance," *Insurance Law Journal* 613 (1974): 69; O'Connell, "No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage," *Emory Law Journal* 24 (1975): 21.

⁹² See Tancredi, "Designing a No-Fault Alternative," *Law and Contemporary Problems* 49 (1986): 277; American Bar Association, *Designated Compensable Event System: A Feasibility Study* (1979). The latest iteration of the concept is the ACE (accelerated compensable event).

⁹³ See Gellhorn, "Medical Malpractice Litigation (U.S.)—Medical Mishap Compensation (N.Z.)," *Cornell Law Review* 73 (1988): 170.

Sweden⁹⁴ to answer the critics of no-fault and to develop realistic approaches to an administrative compensation system.⁹⁵ In both Britain and Canada, there is sentiment for use of a no-fault model.⁹⁶ In this country, the states of Virginia and Florida have put into effect no-fault compensation plans for neonatal neurological injury.⁹⁷

How does a no-fault system work for compensation of medical injury? In Sweden, a combine of insurance companies provides a no-fault insurance program.⁹⁸ Complementing, yet separate from, the insurance compensation plan is the Medical Responsibility Board (MRB) that hears complaints about quality of care rendered to individuals.⁹⁹ The advantage of uncoupling the compensation and deterrent approaches to medical injuries as the Swedes have done is that it frees both functions from the adversarial notions of tort litigation, providing greater and more equitable compensation and stronger deterrence signals.¹⁰⁰

Nonetheless, there are significant problems with the no-fault approach. Many have argued that our major present-day use of no-fault within workers' compensation has failed to provide appropriate compensation for individuals suffering from occupational diseases.¹⁰¹ Still others fear that a no-fault approach

would do away with the deterrent effect of medical malpractice litigation. This contention, however, overlooks the fact that no-fault is still a mode of legal liability with one party required to compensate the victims of its activities, and the requisite insurance would likely be provided at the level of hospital or other health care organization where premiums could be strongly experience rated.¹⁰²

Recently, we have completed a study of medical injury, and the costs arising out of such injury, in the state of New York. The data from this study indicate that in New York, at least, one can provide full compensation for the net financial losses of all seriously injured patients for roughly the same amount expended on litigation for only a selected number of those negligently injured.¹⁰³

Social Insurance—The relationship between providing health insurance for all Americans and tort reform must be underlined, because comprehensive health benefits would deal directly with many of the patient losses for which malpractice litigation now seeks redress. One major advantage of the Swedish and New Zealand systems for no-fault insurance for medical injury is that these compensation systems are nestled within a much more encompassing safety net of social welfare programs. For instance, in Sweden, there is a national health system that provides medical care for all individuals and comprehensive disability insurance for lost earnings. Thus their no-fault system does not absorb much of the costs arising out of an iatrogenic injury, and the smaller stake in the outcome reduces the intensity of conflict in individual cases.

Broader disability insurance and sick leave benefits would also decrease the overall costs associated with compensation programs for iatrogenic injury. When a collateral source offset is in place, any increase in the coverage of first party loss insurance correspondingly reduces the losses left to be handled by the much more expensive system of third party malpractice insurance.

Beyond Health Care Providers—Malpractice litigation is not the only aspect of tort law that plays a major role in the health care area. Just as prominent and often just as troubling are product liability suits against manufacturers of vaccines, prescription drugs and other medical appliances. Indeed, many of these cases are the result of the combined action of a manu-

⁹⁴ See Rosenthal, *Dealing With Medical Malpractice: The British and Swedish Experience*, (1988) 131-206.

⁹⁵ See Halley, Fowks, Bigler, Ryan, *Medical Malpractice Solutions: Systems and Proposals for Injury Compensation* (Springfield, Ill., Charles Thomas 1989).

⁹⁶ See British Medical Association, *No-Fault Compensation Working Party Report* (1987); R. Prichard, *Medical Malpractice* (1989).

⁹⁷ See White, "Innovative No-Fault Tort Reform for an Endangered Specialty," *Virginia Law Review* 74 (1988): 1487. Some have criticized the Virginia system for only controlling cases of people who would probably recover in the tort system, thereby resulting in less compensation for them and no more compensation for others. See Gallup, "Can No-Fault Compensation of Impaired Infants Alleviate the Malpractice Crisis in Obstetrics?" *Journal of Health Politics, Policy and Law*, 14 (1989): 69.

⁹⁸ A patient seeking compensation for medical injury must merely show that her injuries are of a designated type and compensation is available. There need be no allegation of negligence, and thus physicians often assist their patients in the effort to secure compensation. See Oldertz, "The Swedish Patient Insurance Scheme—Eight Years of Experience," *Medical Legal Journal* 52 (1984): 43.

⁹⁹ Most such complaints are brought by patients but physicians are encouraged to self-report to their department heads who in return report to the MRB. The MRB can discipline physicians who provide poor quality care or can decide that no action is necessary. The MRB has both expert input and political and citizen representatives, similar to the boards envisioned by the AMA's fault-based system.

¹⁰⁰ Patient compensation is more straightforward in the absence of the corrective justice aspects of tort litigation. Physicians can actually assist patients in their efforts to receive compensation. On the other hand, since compensation is not directly sought from the physician or his insurer, data regarding sub-standard care is more freely available. Quality assurance efforts proceed smoothly, free from concerns about investigations by plaintiffs attorneys regarding the quality assurance data. Thus, at least in theory, a no-fault system would provide greater compensation and clearer deterrent signals.

¹⁰¹ See Barth and Hunt, *Workers Compensation and Work-Related Illnesses and Diseases* (1980); see also Kutchins, "The Most Exclusive Remedy is No Remedy At All: Workers Compensation Coverage for Occupational Diseases," *Labor Law Journal* 32 (1981): 219-20. Indeed, one might conjecture that determining causation in medical injury cases may be much more difficult than determining causation in workers' compensation cases in that most patients will have a significant background of disease from which the medical care-induced injury must be disentangled. Thus no-fault approaches to medical injuries will likely have inherently higher administrative costs than workers' compensation.

¹⁰² The best work on workers' compensation and deterrence suggests that workers' compensation has a considerable preventive effect on workplace fatalities. See Viscusi and Moore, *Compensation Mechanisms for Job Risks: Wages, Workers' Compensation and Product Liability* (forthcoming, Princeton University Press).

¹⁰³ See Harvard Medical Practice Study, *Patients, Doctors, and Lawyers* (1990), chap. 8.

facturer which designs and markets the drug and a physician—the learned intermediary—who prescribes the drug for a patient.¹⁰⁴ Thus, any effort to cut back sharply on the tort liability of the doctor is likely to redirect the pressure by the victim for tort relief towards the manufacturer (as has recently been evident in the rise of third party product suits by employees covered by no-fault workers' compensation). Because drug manufacturers do operate within a national market, the federal government must be especially sensitive to the possible impact of measures directed at doctors and patients alone.¹⁰⁵ This is not to imply that there is no legitimate federal responsibility for malpractice law itself. As the largest third party purchaser of health care, the federal government must be concerned about the impact of tort litigation on the costs and quality of that care. In addition, the federal government must be sensitive to the way its own legal policies (e.g., antitrust) interact with and occasionally obstruct the efforts by individual states to improve the situation.¹⁰⁶

¹⁰⁴ See Shulman, "The Broader Message of Acutane," *American Journal of Public Health* 79 (1989): 1565–1570. For a recent, revealing illustration of this phenomenon, see *O'Gilvie v. International Playtex, Inc.*, 821 F. 2d. 1438 (10th Cir. 1987), where a doctor's misdiagnosis of toxic shock syndrome precipitated an \$11.5 million jury verdict against the product manufacturer, including \$10 million in punitive damages.

¹⁰⁵ In Sweden, the institution of a no-fault insurance approach to medical injury was wedded to a no-fault program for compensation for drug related injuries, a program which is underwritten by drug companies. See Rosenthal, *Dealing With Medical Malpractice: The British and Swedish Experience*. In this country, a no-fault system for vaccine related injury has recently been instituted by the United States Congress. Vaccines represent one of the two exceptions to the learned intermediary rule and thus vaccine manufacturers must provide patients with a warning concerning the risks associated with vaccination. See *Reyes v. Wyeth Laboratories*, 498 F.2d 1264 (5th Cir. 1973), cert. denied, 419 U.S. 1096 (1974). At least partially as a result of this requirement regarding warning, vaccine manufacturers have faced a great deal of product liability litigation arising out of parties injured by vaccines. See Institute of Medicine, *Vaccine Supply and Innovation* (1985).

In response, Congress passed an amendment to Title III of the Omnibus Health Legislation which was known as the National Childhood Vaccine Injury Act. See S.1744, 99th Cong., 2d sess. (1986). The Act creates a mandatory no-fault compensation scheme for individuals injured by childhood vaccines. An injured party may either accept compensation awarded through the no-fault proceeding or bring a separate civil suit, but in the latter circumstance, theories of liabilities are significantly limited. Under the no-fault scheme, burden of proofs are lower, as is the potential compensation. A trust fund, consisting of an excise tax on dosages of childhood vaccine, provides compensation. See Budget Reconciliation Act of 1987, P.L. 100–203, sec. 4301–07.

Of course, childhood vaccines may be a special case. They are a necessary public health tool but not an area of great profit making by drug companies. Therefore, the industry's threats to absent itself from the marketplace in this particularly important area are likely to bring about Congressional intervention. Other types of drugs might have less of a claim on Congressional attention. Nonetheless, the Vaccine Act demonstrates that tort reform could extend itself to drugs and other products. We await some further maturation of this program so as to evaluate how well it functions.

¹⁰⁶ Consider the following example. New York State's Malpractice Reform Bill of 1986 required hospitals to purchase excess coverage for physicians practicing on the staffs of the hospitals. Thus the hospitals had to bear new costs. They passed these costs along to Blue Cross/Blue Shield, commercial insurers, and to the state Medicaid program. However, federal Medi-

CONCLUSION

We have reviewed a broad array of issues posed by malpractice litigation for the health care system. In the mid-70's and in the mid-80's, providers in many regions of the country felt grave concern about spiraling liability costs. Although much of the hue and cry has died down now that premium levels have plateaued, the empirical research we reviewed earlier shows there is ample room for another upsurge in the 90's in malpractice claims and premiums.

In the interim, a host of policy changes have been proposed and adopted within each of the health care, legal, and insurance systems whose interplay generates the observed rates of patient injuries, tort claims, and premium costs. We were asked to provide here a review of the arguments for and against these various ideas, not to spell out and to defend our own favored proposals. As we have tried to indicate, though, there are no easy solutions to this complex set of problems: indeed, apparently desirable changes in one area of the law (e.g., antitrust) may run counter to equally appealing initiatives taken elsewhere (e.g., quality assurance through peer review). Too often conventional tort reform has reflected a rather narrow view not just of the actual source of the problems posed by malpractice litigation for doctors, but also of the need for some such liability mechanism to insure safe care for patients. Recently, some systematic empirical and analytical work has begun to emerge about more fundamental possibilities—e.g., the AMA's administrative fault proposal and the New York state study of the incidence, compensation, and prevention of patient injuries. At this point of time, then, it would be premature to endorse specific proposals for statutory change, especially for enactment at the national level. What is needed, instead, is careful analysis of the growing body of data now available, and the design, implementation, and evaluation of demonstration projects. We would hope that this Commission, whose primary focus is the availability and affordability of medical care, would recommend that a similarly systematic inquiry be mounted about the ways in which malpractice litigation or its alternatives can best enhance the quality of the medical care thereby provided.

care disallowed any reimbursement for these purposes, and the issue is still in litigation. This demonstrates how the prominent federal role in the provision of medical care creates federal interest in tort reform.

DESIGN OF HEALTH PLAN BENEFITS FOR THE NONELDERLY

Janet Lundy *

As you requested, this paper provides background information on health plan benefits and a discussion of a standard, or “basic,” health benefit plan. Also included is a discussion of how health plan benefits are designed to meet certain requirements, such as the need to cover certain population groups (e.g., the low income) or to conform to certain cost constraints. In addition, the paper presents and discusses several health benefit plan options.

The focus of this paper is on fee-for-service plan benefits, which is the most prevalent type of coverage in this country, as opposed to the benefit structure of health maintenance organizations. In addition, the discussion focuses only on health benefits for the nonelderly (under age 65) population.

The specification of the five health benefit plan options was determined in discussions with you. We agreed that we would use three plans already developed by the Congressional Research Service (CRS) as illustrative plans for our project on health insurance for the uninsured: a “typical” private employer-based plan, a “tailored” plan designed for the low-income, and a “catastrophic” plan for medical expenses that are large compared to family income. In addition, you requested that we develop (1) a typical plan that includes preventive services and (2) a reduced typical plan which includes greater enrollee cost sharing and excludes mental health and dental services, but includes preventive services. The relatively lengthy discussion of preventive services responds to your request for information on these frequently uncovered services.

WHAT ARE THE BENEFIT DESIGN FEATURES OF FEE-FOR-SERVICE HEALTH PLANS?

The design of a health plan’s benefits includes several features that define the benefits and help to determine what the benefits will cost. These benefit features include (1) covered services, (2) limits on allowable charges, (3) limits on services covered or total payments, (4) enrollee cost sharing and catastrophic protection, and (5) cost containment features. Only the first feature, covered services, pertains to the types of health care services covered by a plan; the other features define how the costs of health care services are divided between the plan and the plan enrollees.

Covered and Excluded Health Care Services

The major types of health care services that health plans cover include hospital services (inpatient and outpatient), surgical services (inpatient and outpatient), physician services, X-ray and laboratory tests, emergency care, prescription drugs, and mental health care, including substance abuse (inpatient and outpatient). Most employer health plans cover these benefits. What varies more from plan to plan than the types of services covered are the reimbursement levels for each service and the plan’s cost containment features.

Other services sometimes covered in health plans include dental care, vision care, well-baby and child care, preventive care including routine physical examinations, home health services, and care in an extended care facility.

Any costs enrollees incur for services not covered by a health plan (“excluded” services) are neither paid for by the plan nor applied toward the plan’s deductible requirements or catastrophic limits (described below). Examples of services and expenses that are

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not covered under many health insurance plans are cosmetic surgery; infertility services; services not deemed “medically necessary” such as those done for educational, research, or vocational training purposes; experimental treatments; tests or treatments not needed for a particular condition; and services that do not meet generally accepted standards of medical practice. Plans may also specify the type of providers to whom payment can be made for covered services and may exclude treatment by others. For example, a plan may pay for mental health services only if provided by a psychiatrist or psychologist.

Limits on Allowable Charges

Most health plans use some method for determining the extent to which a medical expense is eligible for payment. These methods are designed to exert some control over plan costs by setting limits on the amount of a health care provider’s charges or costs that will be reimbursed. For example, in general, inpatient hospital bills are paid by Medicare under a prospective payment system, by commercial insurers as a percentage of the hospital’s average charge for a semiprivate hospital room, or by Blue Cross and Blue Shield according to contract limits negotiated by the hospital and the Blue plan.

A plan may pay physicians according to a method known as “reasonable and customary” (R&C). Under R&C, payment is made according to the physician’s actual charge for a particular service, limited by a maximum determined as a percentage of the average charge for that service by physicians in the same geographic area. Plans may also pay according to a fee schedule, where the plan establishes maximum payment amounts in each geographic area for each service. Blue Cross and Blue Shield plans generally limit payment to physicians by negotiating contracts under which the physician agrees to accept the Blue plan’s payment as full payment for covered services.

Limits on Services Covered or Total Payments

Health plans frequently set limits on the units of service (e.g., visits or days of care) covered by the plan, or on the maximum dollar amount paid by the plan per service, per year, or over the insured person’s lifetime. For example, a plan’s mental health coverage may limit payment for inpatient mental health care to 30 days per year and limit outpatient mental health care to a maximum number of visits per

year (perhaps 50), with an annual maximum payment of \$1,000 per year.

Enrollee Cost Sharing and Catastrophic Protection

In recent years, health plans have extended their use of enrollee cost sharing, including deductibles and coinsurance, in an attempt to reduce plan costs. A **deductible** is a specific dollar amount, commonly \$100 to \$200, that must be paid by the insured before the health plan will begin paying benefits. Typically, employer plans require the insured to pay a yearly overall plan deductible (also called a “major medical” deductible) prior to plan payment for covered services. **Coinsurance** is a specified percentage of each bill for a covered medical services that the insured must pay, commonly 20 percent. The coinsurance is applied to the remaining covered expenses after any deductible has been met by the insured.

Many plans include as a benefit a yearly limit (also known as a **catastrophic, out-of-pocket, or stop-loss limit**) on the amount of cost sharing (coinsurance and sometimes deductibles) that the insured must pay from their own pockets. After that limit (commonly \$1,000 to \$3,000) is reached, the plan pays 100 percent of any additional expenses for services covered by the plan.

Arguments exist both for and against the use of enrollee cost sharing. Clearly, cost sharing reduces health plan costs because the health plan pays a smaller proportion of the cost of covered health care services. Proponents for cost sharing maintain that requiring enrollees to contribute to the payment of their medical expenses makes them more sensitive to their utilization of medical care, potentially reducing utilization and, thus, health plan costs.

Opponents of the use of enrollee cost sharing argue that it does not reduce utilization since it is physicians, not the patients paying the cost-sharing amounts, who make most decisions about the use of health care services. In addition, it is argued that any reductions in utilization because of cost-sharing requirements are not necessarily desirable, since people may be discouraged from seeking needed medical care.

Studies such as the Rand Health Insurance Experiment (HIE) have found that enrollee cost sharing can lead to lower utilization and lower health plan costs. The HIE found that per capita expenses for enrollees in a plan with a 95 percent coinsurance rate (i.e., the percentage paid by the insured) for outpatient services

were 28 percent lower than expenses for those in a plan with no enrollee cost-sharing requirements.¹

Enrollee cost sharing is sometimes defined to also include the enrollee's share of the premium payment. For typical large and medium private sector employer plans, the employer generally pays the full premium for employee-only coverage, but requires the enrollee to pay about 25 percent of the premium for family coverage.

Cost Containment Features

In addition to enrollee cost-sharing requirements, other features are included in health plans to attempt to control plan costs. These include alternative financing arrangements such as self insurance; premium cost sharing between plan sponsor and enrollee; financial incentives to use services less costly than hospital care, such as home health care, hospice service, urgent care centers, etc.; managed care techniques, such as hospital utilization review and second surgical opinion requirements, and health promotion programs such as smoking cessation, substance abuse, weight reduction, and stress management. Another technique for controlling plan costs is to use preexisting condition clauses, which temporarily or permanently exclude from coverage an enrollee's medical condition that existed prior to coverage by the health plan.

WHO DOES NOT HAVE HEALTH CARE COVERAGE?

An estimated 36.8 million nonaged Americans (17.5 percent of persons under age 65) lack health insurance coverage. Persons who do not privately obtain health insurance, either through their jobs or by purchasing insurance, sometimes receive coverage from Government programs such as Medicaid. However, coverage from Government programs is contingent on meeting certain program eligibility requirements. Those who do not have private coverage and either do not meet the eligibility requirements of Government programs or choose not to participate in them are the 36.8 million (17.5 percent) who are uninsured.² The characteristics of the uninsured are described below.

¹ Willard G. Manning, et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* (June 1987): 251-277.

² The statistics on the uninsured are based on a Congressional Research Service analysis of the March 1987 Current Population Survey (CPS), a household survey conducted by the Census Bureau. The March 1987 CPS collected information on health insurance coverage for 1986. A more detailed description of these statistics can be found in: U.S. Congress, House Committees on Education and Labor, Energy and Commerce, and Senate Special Committee on Aging, *Cost and Effects of Extending Health Insurance Coverage*, 100th Cong., 2d Sess., October 1988.

Age

The uninsured are young: 32 percent are under age 18; 22 percent are age 18-24; and 19 percent are age 25-34.

Employment

More than half (52 percent) of the uninsured are employed; most of the working uninsured (59 percent) are in small firms of less than 100. Workers whose jobs did not provide health insurance tended to be part-time rather than full-time workers, young rather than older workers, lower-paid rather than higher-paid workers, in small firms rather than in large firms. These workers also tended to be employed in the service-producing and retail sectors of the economy. Between two-thirds and four-fifths of the uninsured live in families where someone is employed.

Income

Over half (61 percent) of the uninsured are low income (family income under \$20,000). About 30 percent of uninsured persons live in families with incomes below the Federal poverty threshold for their family size.

ISSUES IN DESIGNING A HEALTH BENEFITS PLAN

General

A health plan's benefits are designed to pay either all or a portion of the health care expenses of the population covered by the health plan. This is presumably the purpose of insurance—to ensure that the health care services used by the covered population are paid for, that unexpected health care expenses can be paid for, and that financial means do not become a barrier to seeking or receiving health care services.

Several questions need to be asked when designing a health benefits plan. These include:

- What benefits will be included? What is a "basic" health benefits plan? How should the population to be covered help determine a plan's benefits?
- What are some health benefit plan options?
- What is the cost of the plan?

—What is the framework for the health plan benefits?

These issues will be discussed below.

What Benefits Will Be Included?

In general, the goal of a health benefits plan is to provide payment for health care services needed or used by the covered population. Health care benefits “needed” by a given population can be defined either in terms of (1) the types of services used by the population to be covered by the health plan (for example, hospital services, outpatient prescription drug services, etc.), or (2) the financial means of the covered population to pay for health services. In designing a health benefits plan, one may wish to consider what is a “basic” health care benefits package.

1. “Basic” Health Care Benefits—There is no clear definition of what comprises a “basic” package of health care benefits. In insurance terminology, most health insurance plans have been categorized as either “basic plus supplemental major medical” or “comprehensive major medical.” This distinction has become more confusing than helpful over the years. However, it is useful to define these terms since they often arise in the description of health insurance plans. “Basic” coverage originally meant coverage of certain expenses that were fully paid for by the insurer without any coinsurance or deductible (also known as “first-dollar coverage”). The most common type of early basic coverage (in the 1920’s and 1930’s) was for hospital services and physician services provided in a hospital setting.

“Major medical” insurance was later designed to cover expenses, such as physician office visits and prescription drugs, that were not covered as “basic” expenses. Major medical coverage is generally characterized by the enrollee payment of a deductible and coinsurance, a high ceiling on the total amount payable by the plan, and a limit on cost-sharing expenditures by enrollees (also called an out-of-pocket or “catastrophic limit”). Since basic and major medical insurance plans were usually combined as one package, although often offered by two different insurers, the package became known as “basic plus supplemental major medical.”

“Comprehensive major medical” insurance originally subjected all covered expenses, including hospital-related expenses, to a common deductible and coinsurance. A typical design would be for the enrollee to pay 20 percent of all covered expenses after paying a \$100 deductible.

Insurance plans have changed over time so that deductibles and coinsurance have been added to the basic coverage of many plans, and hospital and surgery are now covered in full by many comprehensive plans. Therefore, while the terms are still used, there is frequently little distinction between them. It is easiest to focus on individual plan features to understand the nature of a plan’s coverage. This document uses the terms “overall plan deductible” and “overall plan coinsurance” to refer to the major medical features of health plans.

In non-insurance parlance, “basic” health care services, and any health plan benefits that pay for such services, usually refer to some determination of the minimum health services that should be generally and uniformly available in order to assure adequate health status and protection of the population from disease, or to meet some other criteria or standard. However, there is little agreement on what constitutes a “basic” health benefits plan.

Since a single definition of a “basic” benefits package does not exist, it may be helpful to use as a standard a common or typical health benefits package. Most Americans with health plan coverage (approximately 75 percent) are covered by employment-based health plans. While these plans vary considerably, it is possible to develop a hypothetical or composite plan that is typical of the most prevalent benefit provisions found in health plans offered by medium and large firms. The following is a typical 1988 private sector employment-based plan:³

The typical private employment-based plan described above provides coverage for most health care services (hospital, surgical, physician, X-ray and laboratory, emergency, prescription drugs, mental health, and dental). The \$100/\$300 overall deductible (the amount the enrollee must pay out-of-pocket before the plan begins paying benefits) applies to all services except hospital and emergency. The enrollee out-of-pocket costs applied to the annual \$1,000/\$2,000 out-of-pocket (or, “catastrophic”) limit include coinsurance amounts, but not the overall deductible. There is no limit on the maximum amount the plan will pay over the enrollee’s lifetime. The coinsurance percentages are percents of reasonable and customary limits for covered services paid by the plan, except for the hospital room and board coinsurance, which is

³ This “typical” employment-related health plan was developed by the Congressional Research Service and the Hay/Huggins Company (while under contract with CRS), based on data in the 1988 Hay/Huggins Benefit Report, a sample of nearly 900 medium to large employers included in the annual Hay/Huggins Benefits Survey. This data base covers approximately 25 million people who receive health insurance benefits through these employers. See U.S. Congress, House Committee on Post Office and Civil Service, *The Federal Employees Health Benefits Program: Possible Strategies for Reform*, 101st Cong., 1st Sess., May 24, 1989, 138–140.

paid as a percentage of the hospital's semiprivate room rate. Thus, the maximum amount that the enrollee would pay for services covered by this plan would be \$1,100 for an individual plan and \$2,300 for a family plan, assuming that provider charges were not in excess of the plan's reasonable and customary limits.

Typical Private Sector Employment-Based Health Plan, 1988

| Benefit | Plan provision |
|---|-----------------|
| Overall deductible (per person/family; for all benefits except hospital and emergency services). | \$100/\$300 |
| Annual out-of-pocket limit (per person/family; counts only nonmental health coinsurance toward limit). | \$1,000/\$2,000 |
| Lifetime maximum | None |
| Hospital services: | |
| Room and board, 365-day per stay maximum.. | 100% |
| Other hospital expenses..... | 100% |
| Hospital alternatives (extended or home health care). | Yes |
| Surgical services | 80% |
| Physician services | 80% |
| X-rays and laboratory | 80% |
| Prescription drugs | 80% |
| Emergency/accidental injury | 100% |
| Mental health care: | |
| Inpatient care (annual 30-day maximum; subject to overall deductible). | 80% |
| Outpatient care (annual 50-visit maximum; subject to overall deductible). | 50% |
| Dental care: | |
| Routine | 100% |
| Basic | 80% |
| Restorative/reconstructive | 50% |
| Routine physicals and tests | None |
| Well-baby and well-child care | None |

2. Preventive Health Care Services—The typical private employment-based plan does not provide coverage for routine, or “preventive” health care services not related to an illness. These would include periodic check-ups and health screenings (for example, pap smears, mammography, stool exams for occult blood); immunizations (e.g., tetanus, influenza, polio, DPT); and counseling programs (e.g., smoking, alcohol,

weight, exercise). However, as presented in a 1988 report entitled *Implementing Preventive Services*, some believe the “reimburseurs may be shortsighted in failing to provide financial incentives for prevention. If keeping people healthy is cheaper than remedying their illness, then prevention is not only a good investment for society as a whole in terms of the return of health benefits for dollars expended but may be profitable in the narrow sense for the reimbursor as well, by reducing total dollar outlays.” ⁴

The U.S. Preventive Services Task Force released a report in May 1989 (*Guide to Clinical Preventive Services*) that provides recommendations on more than 100 interventions for 60 potentially preventable diseases and conditions, designed to help health care providers select the most appropriate and effective preventive interventions for patients.⁵ The report also includes information on the burden of suffering for the preventable conditions (e.g., morbidity, mortality, cost of treatment, etc.) and the proven effectiveness of the intervention, based on the quality of the published research evidence. The report provides examples of the benefits of including prevention in medical practice, including:

- the decline of infectious diseases such as poliomyelitis, rubella, diphtheria, and pertussis due to childhood immunization;
- reductions in morbidity and mortality due to early detection of diseases such as stroke (through screening for hypertension), cervical cancer (through pap tests), and childhood metabolic disorders (through routine newborn screening and treatment);
- effects on the leading causes of death through counseling on personal health behaviors such as smoking, physical inactivity, diet, sexual practices.

The report cited lack of reimbursement for preventive services as one reason why physicians often fail to provide recommended clinical preventive services.

However, the effects of preventive services on health status and on cost are not entirely clear. Certain preventive services, such as immunizations, are not without risk (and resulting cost). Other preventive services, such as tests for hypertension, will not in themselves result in improved health status, and follow-up therapy, such as drug therapy for high blood pressure, will not necessarily reduce medical

⁴ Robert G. Evans, “Economic Barriers to Preventive Services: Clinical Obstacle or Fiscal Defense,” in *Implementing Preventive Services*, ed. Renaldo N. Battista and Robert S. Lawrence, *American Journal of Preventive Medicine* (New York: Oxford University Press, 1988), 114.
⁵ U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services* (Washington, D.C.): 1989.

expenditures. As stated in *Is Prevention Better Than Cure?*, “The evidence also shows that, even after allowing for savings in treatment, prevention usually adds to medical expenditures, contrary to the popular view that it reduces them. Evaluations of a number of significant preventive measures—several of which have been reviewed in this study—support this conclusion. . . . In some cases prevention may save money in other, nonmedical, sectors of the economy. Studies of the measles vaccine and of lead screening for young children both indicate that these procedures reduce expenditures for institutionalization and special education by preventing retardation among children. It is not possible, however, to conclude that there are usually savings elsewhere because most analyses have not looked beyond medical expenditures. . . . What really matters is not whether a preventive measure adds to costs in a particular sector, or reduces them, but the total costs it involves, wherever they occur. These results show that prevention cannot be assumed to be a better choice than cure in every case. Individual measures must be evaluated on their merits.”⁶

Prenatal care is considered another type of preventive service. As discussed in a 1987 report by the Office of Technology Assessment (OTA), *Healthy Children: Investing in the Future*, “prenatal care encompasses a wide range of preventive, diagnostic, and therapeutic service delivered throughout the course of pregnancy, with the goal of both a healthy baby and a healthy mother. . . . Because prenatal care includes not only preventive interventions such as screening and counseling but also treatment when needed, it is bound to be effective in altering the health of some mothers and infants.”⁷

Although OTA found shortcomings in almost all the studies of prenatal care reviewed, it concluded that “the weight of the evidence from more than 55 studies of the effectiveness of earlier, more frequent, or enriched prenatal care services supports the contention that two key birth outcomes—low birthweight and neonatal mortality—can be improved with earlier and more comprehensive prenatal care, especially in high-risk groups such as adolescents and poor women. . . . OTA estimated that for every low birthweight birth averted by earlier or more frequent prenatal care, the U.S. health care system saves between \$14,000 and \$30,000 in newborn hospitalization, rehospitalization in the first year, and long-term health care costs associated with low birthweight.”⁸

Another study, *The Financing of Maternity Care in the United States*, conducted by the Alan Guttmacher Institute, found that in 1980, 8 percent of mothers received insufficient prenatal care and 26 percent received an intermediate level of care; 66 percent obtained sufficient care.⁹ For 1980, the sources of payment for prenatal care were found to be as follows: private insurance (41 percent), the mother and/or her family (35 percent), Medicaid (8 percent), other (16 percent). For women whose incomes were 150–199 percent of poverty, 70 percent paid for their prenatal care themselves.¹⁰

Private insurance coverage of prenatal care varies according to the size of the employer (for employer-based coverage) and State law and regulations. The Pregnancy Discrimination Act of 1978 (P.L. 95–555) requires employers of 15 or more employees, and self-insured employers, who offer health insurance to cover pregnancy care in the same manner as other medical care. Thus, coverage of prenatal care is implicit in most plans of employers with 15 or more employees. However, small employers, nonspouse dependents, and those with privately obtained insurance coverage not related to the workplace are not covered by the Pregnancy Discrimination requirement. Such plans may exclude or limit their benefits for prenatal care; waiting periods, pre-existing condition clauses, and exclusion of coverage for nonspouse dependents (e.g., a teenage daughter) may also affect coverage of prenatal care.¹¹

3. Enrollees’ Financial Means—Implicit in determining a standard for “basic” health care benefits is an understanding of financial means of the population to be covered by the health plan. The financial means of the population is important in determining whether the health plan covers a “sufficient” proportion (however defined) of the medical expenses of the enrollees and thus assures that their income is not a barrier to their receiving and paying for medical services.

If a health plan’s benefits cover the full cost of the medical bills incurred by enrollees and no premium contribution is required of enrollees, then the income of the enrollee is irrelevant in determining whether the health plan makes health care services affordable for the enrollee. But the benefits of all current health plans, both public and private, leave the enrollee with certain out-of-pocket costs. These out-of-pocket costs result from uncovered services, services in excess of the plan’s limits on number of days or visits, cost-sharing amounts such as deductibles and coinsurance,

⁶ Louise B. Russell, *Is Prevention Better Than Cure?* (Washington, D.C.: The Brookings Institution, 1986), 110–111.

⁷ Office of Technology Assessment, *Healthy Children: Investing in the Future* (Washington, D.C.: Government Printing Office, 1987), 8.

⁸ *Healthy Children*, 9.

⁹ The Alan Guttmacher Institute, *The Financing of Maternity Care in the United States* (New York, N.Y.: December 1987), 27.

¹⁰ *Financing Maternity Care*, 105.

¹¹ *Financing Maternity Care*, 263.

the portion of providers' charges in excess of the plan's payment limits (also known as "balance billing"), and premium amounts required of enrollees.

Theoretically, the goal of most insurance is to provide payment for the most unexpected and costly of events. This goal would lead one to, at the very least, design benefits to cover catastrophic health care expenses. However, a medical expense that is financially catastrophic to a low income individual or family may be a routine, budgetable amount for a wealthy person or family. This dilemma highlights the issue of how to provide health plan coverage of large medical bills.

"Catastrophic" health plan benefits are those which provide protection against the high cost of treating severe or lengthy illness or disabilities. Thus, it is not the severity of the illness but its expense that determines whether it is catastrophic in a financial sense. There is no commonly accepted definition of what constitutes a catastrophic medical expense, except that the expense must be the liability of the individual or family and not reimbursable by some health plan. This lack of definition arises in part because its determination depends on the financial resources of the individual or family to pay for the expense. Two methods are commonly used to define catastrophic expenses.

The first method uses a fixed-dollar threshold (for example, \$2,000) to determine whether out-of-pocket (uninsured) expenses are catastrophic. The second method measures the out-of-pocket expense relative to the income of the individual or family (for example, 10 or 15 percent of income). The income-related measure, while tailoring benefits to the financial circumstances of the covered population, is administratively more complex. The threshold level and the method chosen to determine whether the limit has been reached can lead to very different results in terms of the numbers and characteristics of those at risk for catastrophic expenses.

Thus, whether a person's medical expenses are "catastrophic" depends on the extent of their health plan coverage (if any) and their ability to pay. The features of a health plan that help determine whether it provides catastrophic coverage include (a) the extent of its benefits, particularly for the more expensive services such as inpatient hospital care (e.g., coverage for 365 days of inpatient hospital care rather than 30 days), and (b) any out-of-pocket (e.g., "catastrophic") limit on enrollee cost-sharing amounts, which is usually a fixed-dollar amount above which the plan pays 100 percent of the allowable charges for covered services. Since most health plans, whether private or public, pay for acute care services only, the catastrophic features of current health plans generally do

not cover catastrophic expenses associated with long-term care services.

Most private employment-based health plans limit out-of-pocket liability through the first method, a fixed-dollar limit, typically \$1,000 per person or \$2,000 per family in medium to large employer health plans. According to the Employee Benefit Research Institute (EBRI), only 4 percent of workers in medium to large employer plans have out-of-pocket limits based on a measure of income, their earnings.¹²

4. Population To Be Covered—Determining the characteristics of the population to be covered is basic to the design of a health benefits plan. For example, is it intended that the health benefits cover all of the uninsured or a target group such as uninsured children, uninsured workers and families, low-income mothers and children, or those who are medically high risk because of a preexisting illness? Is the plan to be affordable to those of varying income levels?

Once the covered population and its characteristics (e.g., age, income) are determined, a health plan can be designed so that it covers the types of services suited to the population and with cost-sharing amounts (and at a premium, if required) that the population can afford. If the target population is children, then coverage of preventive services such as prenatal and well-baby/well-child care could be included. If the plan is to be affordable to those of all incomes or if the low-income are targeted for coverage, then large cost-sharing amounts (deductibles and coinsurance) may not be appropriate.

The issue of affordability is complicated by the fact that if the enrollee is required to pay all or a portion of the premium, one way of reducing the premium cost so it is more affordable for low-income enrollees is to raise the plan's cost-sharing requirements. However, this would mean that although all enrollees (including the low income) would pay lower premiums, enrollees who use medical care services would pay a larger share of their medical bills because of the larger cost-sharing requirements, which could be a burden to the low-income with medical bills.

5. Other Health Benefits Issues—Other questions may be raised about the coverage included in a health benefit plan. Will the plan cover benefits for pre-existing conditions? What type of provider may provide the services and be paid or reimbursed by the health plan? For example, will the plan pay for services provided by nonphysician providers? Will experimental

¹² Employee Benefit Research Institute, *Financing Catastrophic Health Care Costs Among the Nonelderly Population*, EBRI Issue Brief No. 71 (Washington, D.C.: October 1987).

technologies be covered and, if so, under what guidelines?

Health Benefit Plan Options

Described below are health plan options that vary in the types of health care services covered and in their cost-sharing requirements. These variations attempt to include benefits tailored to the needs and financial means of different populations, as discussed above.

It is assumed that all options cover prenatal care and none exclude coverage for preexisting conditions. The percentages given are the proportion of covered expenses paid by the plan.

1. Option 1: The Typical Plan—The term “typical” is used here to describe a plan whose benefits are typical of plans sponsored by large and medium private employers (as described in more detail above). In summary, such plan provides comprehensive cover-

age of medically necessary services and a catastrophic limit on out-of-pocket expenses. It does not cover preventive services such as routine examinations, screening tests, or well-baby/well-child care. The specific benefits are included in the table below.

2. Option 2: Typical Plan Plus Preventive Care—Research indicates that certain preventive care services (immunizations, screening, and counseling) can prevent or mitigate the effects of disease. Although theoretically all persons could benefit from health plan coverage of preventive care services, presumably the low income would benefit the most. While those of higher incomes may seek out and receive preventive services (such as immunizations) whether or not they are covered by insurance, the low income are more likely to go without such services if they are not covered. Therefore, this option includes all the benefits of the typical plan, plus coverage of (a) routine physicals and tests, and (b) well-baby/well-child care, both of which are subject to the overall plan deductible and are paid for at 80 percent of the reasonable and customary charges.

Option 1: The Typical Plan

| Benefit | Plan provisions |
|--|-----------------|
| Overall deductible (per person/family; applies to all benefits except hospital and emergency services). | \$100/\$300 |
| Annual out-of-pocket limit (per person/family; counts only nonmental health coinsurance toward the limit). | \$1,000/\$2,000 |
| Hospital services (365-day per stay maximum). | 100% |
| Hospital alternatives (extended or home health care). | Yes |
| Surgical services | 80% |
| Physician services | 80% |
| X-rays and laboratory | 80% |
| Prescription drugs | 80% |
| Emergency/accidental injury | 100% |
| Mental health care: | |
| Inpatient care (annual 30-day maximum; subject to overall deductible). | 80% |
| Outpatient care (annual 50-visit maximum; subject to overall deductible). | 50% |
| Dental care: | |
| Routine | 100% |
| Basic | 80% |
| Restorative/reconstructive | 50% |
| Routine physicals and tests | Not covered |
| Well-baby/well-child care | Not covered |

Option 2: Typical Plan Plus Preventive Care

| Benefit | Plan provisions |
|---|-----------------|
| Overall deductible (per person/family; applies to all benefits except hospital and emergency services). | \$100/\$300 |
| Annual out-of-pocket limit (per person/family; counts only nonmental health coinsurance towards the limit). | \$1,000/\$2,000 |
| Hospital services (365-day per stay maximum). | 100% |
| Hospital alternatives (extended or home health care). | Yes |
| Surgical services | 80% |
| Physician services | 80% |
| X-rays and laboratory | 80% |
| Prescription drugs | 80% |
| Emergency/accidental injury | 100% |
| Mental health care: | |
| Inpatient care (annual 30-day maximum; subject to overall deductible). | 80% |
| Outpatient care (annual 50-visit maximum; subject to overall deductible). | 50% |
| Dental care: | |
| Routine | 100% |
| Basic | 80% |
| Restorative/reconstructive | 50% |
| Routine physicals and tests | 80% |
| Well-baby/well-child care | 80% |

3. Option 3: Reduced Typical Plus Preventive Care— This benefit package includes coverage of the services historically covered by insurance plans, including hospital, surgical, physician, X-rays and lab, prescription drugs, and emergency/accidental injury care. It also includes coverage of preventive services such as routine physicals and tests, and well-baby/well-child care. In order to reduce the cost of the plan, Option 3 (a) does not include coverage of mental health care and dental benefits, and (b) has higher enrollee cost-sharing amounts and a higher annual out-of-pocket limit than Option 1 (the Typical Plan).

While the total premium for this plan would be lower than that of Option 2 (Typical Plan Plus Preventive Care) because mental health and dental benefits are not included and the enrollee cost sharing is increased, the plan is more costly to enrollees because they are required to pay a greater share of their covered medical expenses. Thus, this plan would not be as appropriate for low income enrollees.

Option 3: Reduced Typical Plus Preventive Care

| Benefit | Plan provisions |
|--|-----------------|
| Overall deductible (per person/family; applies to all benefits except hospital and emergency services). | \$200/\$400 |
| Annual out-of-pocket limit (per person/family; counts only nonmental health coinsurance towards the limit). | \$2,000/\$4,000 |
| Hospital services (365-day per stay maximum). | 80% |
| Hospital alternatives (extended or home health care). | Yes |
| Surgical services | 75% |
| Physician services | 75% |
| X-rays and laboratory | 75% |
| Prescription drugs | 75% |
| Emergency/accidental injury | 100% |
| Mental health care | Not covered |
| Dental care | Not covered |
| Routine physicals and tests | 75% |
| Well-baby/well-child care | 75% |

4. Option 4: Tailored Plan—This plan is the same as the “tailored” plan designed by the Congressional Research Service as an illustrative plan tailored to the perceived health care needs of the currently unin-

sured population.¹³ The plan’s benefits were chosen in order to meet two goals. First, the plan was designed to be less costly. Second, it was designed for the uninsured, who are a relatively young, lower-income population. Thus, the plan places more emphasis on preventive care than Option 1 (the Typical Plan), and has lower deductibles and coinsurance. To meet these cost and benefit objectives, this plan was designed with less coverage for long hospital stays (14-day annual maximum) and with no annual out-of-pocket limit. There is no annual out-of-pocket limit because the enrollee is responsible for few cost-sharing amounts.

Option 4: Tailored Plan

| Benefit | Plan provisions |
|--|------------------|
| Overall deductible (per person/family; applies to all benefits except emergency services) | \$50/\$150 |
| Annual out-of-pocket limit | None |
| Hospital services (14-day per stay maximum).... | 100% |
| Hospital alternatives (extended or home health care). | Not covered |
| Surgical services | 100% |
| Physician services | 100% |
| X-rays and laboratory | 100% |
| Prescription drugs | \$2/prescription |
| Emergency/accidental injury | 100% |
| Mental health care | Not covered |
| Dental care | Not covered |
| Routine physicals and tests | 100% |
| Well-baby/well-child care | 100% |

5. Option 5: Catastrophic Plan—This plan is the same as the catastrophic plan designed by the Congressional Research Service as an illustrative plan designed to deal solely with the circumstance of individuals whose medical expenditures are quite large relative to their incomes.¹⁴ The plan requires a deductible related to income and family size before benefit eligibility would begin. The deductible would equal 25 percent of total income less personal exemptions (e.g., family size) for families with total income no greater than \$75,000. For families with total income above \$75,000, the deductible would be 25

¹³ U.S. Congress, House Committees on Education and Labor, Energy and Commerce, and Senate Special Committee on Aging, *Cost and Effects of Extending Health Insurance Coverage*, 100th Congress, 2d Sess., October 1988, 63–139.
¹⁴ *Extending Health Insurance Coverage*, 63–139.

percent of total income less personal exemptions for the first \$75,000 of total income, and 35 percent of any income above \$75,000. For example, a family of four with total income of \$20,000 would have a deductible of \$3,100 (assuming personal exemptions are \$1,900 each).

Under Option 5, if an enrollee's out-of-pocket family health care expenditures exceed the income-related deductible, the enrollee would be required to pay coinsurance of 10 percent on the first \$5,000 of covered expenditures in excess of the deductible. Thus, maximum yearly out-of-pocket liability for covered expenses under this option would equal the deductible plus \$500.

Option 5's cost would be significantly less than that of the other more comprehensive plan options because of its uncovered services (mental health, dental, routine physicals and tests, and well-baby/well-child care) and its large enrollee cost-sharing amounts.

Option 5: Catastrophic Plan

| Benefit | Plan provisions |
|---|-----------------------------------|
| Overall deductible (applies to all benefits) .. | Related to income and family size |
| Annual out-of-pocket limit | \$5,000 |
| Hospital services (365-day per stay maximum). | 90% |
| Hospital alternatives (extended, home health care). | 90% |
| Surgical services | 90% |
| Physician services | 90% |
| X-rays and laboratory | 90% |
| Prescription drugs | 90% |
| Emergency/accidental injury | 90% |
| Mental health care | Not covered |
| Dental care | Not covered |
| Routine physicals and tests | Not covered |
| Well-baby/well-child care | Not covered |

Plan Cost

The total cost of a health plan is a function of several factors, including health benefits design, the cost

of medical care in a given geographic location, and the type and amount of services used by an individual or group covered by the plan.

One health benefits design issue is to fashion the benefits so that the plan's cost is affordable for the payer (e.g., the employer, the enrollee [if premium contributions are required], or the government). This goal is frequently in conflict with the goal of providing comprehensive coverage, since plan affordability is generally achieved either by (1) limiting benefits, which lowers the total plan costs, or (2) sharing costs between the plan sponsor and the enrollee in such a way that the enrollee pays a lesser or greater share of the cost of the benefits and the premiums, which results in increased or lowered cost to the plan sponsor.

As described in the various health plan options above, health plan design can be altered to attempt to meet certain cost requirements. A plan designed for the low income (such as Option 4, the Tailored Plan) would have little or no enrollee cost-sharing requirements (e.g., deductibles, coinsurance) because these would serve as financial barriers to care.

What Is the Framework for Health Plan Benefits?

Clearly, once a health benefits plan has been determined, it needs a framework or setting in which it will be applied. For example, the health benefits plan can be used in the following settings:

- a minimum or standard plan which must be covered by all State Medicaid programs,
- a minimum or standard plan that all employers must offer under an employer mandate,
- a minimum or standard plan that any insurer can market,
- a minimum plan or standard plan that must be sold/purchased in order for the seller or purchaser to receive favorable Federal tax treatment, or
- a minimum or standard plan for universal health insurance coverage.

The setting will determine the population to be covered by the plan and also will focus more clearly a decision on how the health plan will be paid for (i.e., by the Federal Government, by employers, by enrollees, etc.).

PREVENTIVE HEALTH SERVICES

Melvina Ford and Mark Merlis *

This memorandum is in response to your request for information on preventive health services. It does not include public health initiatives in reduction of environmental hazards, or in industrial or public safety, but focuses on preventive services that can be provided in clinical settings.

The first section of the memorandum defines preventive health services. The second section contains data on utilization of the most commonly studied preventive services and some of the factors affecting utilization. The third section of the memorandum describes provisions for covering preventive services under public and private health insurance plans. The fourth section reviews evidence on the benefits of preventive services and the recommendations that are made by professional associations and others for the use of preventive services.

DEFINITION OF PREVENTIVE SERVICES

Preventive health services may be divided between primary services, which are intended to prevent or delay the onset of disease, and secondary services which have the goal of detecting illness early enough for effective treatment. In clinical practice, the provision of preventive services takes the form of immunizations, screening, and health education and counseling. In addition, periodic health examinations, prenatal care and well-child care provide opportunities for identifying medical problems and lifestyle factors that may place a person at particular risk for disease.

Immunizations create resistance to infectious and communicable diseases. Administered to persons who show no evidence of disease, immunizations almost

completely prevent the occurrence of disease. Children are routinely given a basic series of immunizations. For adults, tetanus immunizations are recommended every 10 years and others are recommended according to age and other risk factors.

Screening consists of standardized examinations applied to individuals who have no symptoms of disease, in order to detect disease or a precursor early enough for effective treatment. For example, newborn babies are routinely tested for certain conditions which, without early detection and treatment, result in severe mental retardation. If a screening procedure is to result in an improved outcome relative to conventional diagnosis after symptoms are present, the procedure should accurately detect an early stage of a disease or condition sooner than it could be detected without the screening examination, and there should be an effective therapy available for treating the condition.

Education and counseling interventions provide information and advice regarding personal behaviors to reduce the risk of subsequent illness.

Periodic health examinations (PHE) are overall screening examinations. The frequency and content are tailored by the clinician to the patient's age, sex, medical history, and personal habits. The tailoring allows the clinician to use the preventive measures likely to be most effective for each patient.

Prenatal care encompasses a range of preventive, diagnostic and therapeutic services delivered with the goal of improving birth outcomes and the health of the mother. Preventive care can consist of education and counseling or screening for potentially harmful conditions in the mother or child.

Well-child care consists of various health services aimed at improving the health of children and having a favorable influence on their health as adults. Major

* Report prepared by Melvina Ford, Analyst in Social Legislation and Mark Merlis, Specialist in Social Legislation, Education and Public Welfare Division, Congressional Research Service, February 1, 1990.

aspects of well-child care are immunization and health supervision. Immunizations are standardized and required by State laws. Health supervision includes periodic health examinations, health education and parental counseling.

DATA ON UTILIZATION OF PREVENTIVE SERVICES ¹

There is a limited number of studies on the extent to which preventive services are offered by clinicians or received by patients. The studies that do exist do not investigate the use of preventive services in general, but are limited to specific procedures such as mammograms, or to specific illnesses or risk factors such as coronary heart disease or smoking. This leaves a lack of data on utilization of periodic examinations. Studies may be further limited by small sample sizes, non-random samples or confined geographic areas. This section reviews available utilization data from national studies or surveys. Some of the studies relied on in this section compare utilization to standards or recommendations that are discussed in greater detail later in this memorandum.

Children

There is very little information on children's utilization of health supervision or other preventive services. The one service category for which adequate data exist is immunization. The Centers for Disease Control estimates immunization levels for children entering school at 98 percent in 1989.² Among children under age 2, it is estimated that 75 to 80 percent have received the basic immunization series.³ Levels of immunization are 10 to 16 percent lower for non-white children and for children living in central city areas.⁴ Many parents delay having their children immunized until school entry age. As a result, because it is often the pre-schoolers who succumb to childhood diseases, control of vaccine-preventable diseases is weakened.

¹ In this section, data from the Louis Harris and Associates survey and from the 1982 National Health Interview Survey are from: U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion, *Disease Prevention/Health Promotion, THE FACTS* (Palo Alto, Calif.: 1988).

² U.S. Department of Health and Human Services, *Fiscal Year 1990 Justification of Appropriation Estimates for Committee on Appropriations*, vol. 2 (Washington, D.C.: 1989), 61.

³ U.S. Department of Health and Human Services, Public Health Service, Draft of *Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation* (Washington, D.C.: 1989). (Hereafter cited as U.S. Department of Health and Human Services, Draft of *Promoting Health/Preventing Disease*.)

⁴ U.S. Congress, Office of Technology Assessment, *Healthy Children: Investing in the Future* (Washington, D.C.: Government Printing Office, February 1988), 143. (Hereafter cited as Office of Technology Assessment, *Healthy Children*.)

Adult Immunizations

Information on adult immunization status is fragmented. The Public Health Service (PHS) has estimated that in 1985 10 percent of the non-institutionalized high risk population had received pneumococcal vaccine and 20 percent had received influenza vaccine; the goal of the PHS for the year 2000 is immunization of 60 percent of this population.⁵ Studies show use of influenza vaccine about 60 percent of the time it is indicated.⁶ With no baseline data available, the goal of the PHS for the year 2000 is 80 percent immunization against pneumococcal pneumonia and influenza among institutionalized chronically ill and elderly.⁷

Adult Screening

Data from the 1982 National Health Interview Survey (NHIS) suggests that use of screening services increases with education and income. About 90 percent of the women reported ever having a Pap smear or breast examination. Women with less than 12 years of education and household incomes under \$10,000 were more likely never to have had either examination.

A national survey conducted by Louis Harris and Associates in 1985 supported findings from the NHIS. For example, while 78 percent of the women reported having a Pap smear every 1 or 2 years, this was most likely among women with some college education and household incomes of \$25,000 or more. Similarly, as 48 percent of the respondents claimed to have annual cholesterol testing, those most likely to have been tested were over 40 years old and in a \$50,000 income bracket.

Both the Louis Harris survey and the NHIS found that over 85 percent of the population received annual blood pressure readings with no differences in income, occupation or education. The Louis Harris survey found that blacks were most likely to have a blood pressure reading more often than once a year.

Makuc, et al., comparing data from the 1973 and 1974 National Health Interview Surveys to data from the 1985 National Health Interview Surveys con-

⁵ U.S. Department of Health and Human Services, Draft of *Promoting Health/Preventing Disease*, 12-14.

⁶ Charles E. Lewis, "Disease Prevention and Health Promotion Practices of Primary Care Physicians in the United States," in *Implementing Preventive Services*, eds. Renaldo N. Battista and Robert S. Lawrence (New York: 1988), 9-15. (Hereafter cited as Lewis, *Implementing Preventive Services*.)

⁷ U.S. Department of Health and Human Services, Draft of *Promoting Health/Preventing Disease*, 2-14.

firmed that black women are most likely to be tested, not only for hypertension but, in 1985, for cervical and breast cancers as well. The researchers found that while poor women continued to be least likely to be screened, they had made substantial gains in the use of tests over the period. In 1985, the percent of women with a recent Pap test or breast exam was 10 to 13 percentage points lower among poor women than among the non-poor with two exceptions: among black women 60 to 79 years of age, the difference was only 4 percentage points lower for Pap smears and 5 percentage points lower for breast examinations. Between 1973 and 1985, the percent of women with recent breast examinations increased more for the poor of both races than for the non-poor. Also, the percentage of women who had never had a Pap smear or a breast examination was highest among older poor women (18%) than among other subgroups. However, it was older poor women and black women who accounted for substantial gains in the use of tests between 1973 and 1985.⁸

Prenatal Care

Although 93 percent of the mothers responding to the Louis Harris survey mentioned above reported having sought prenatal care during the first 3 months of pregnancy, other sources indicate the national number is closer to 75 percent.⁹ The 25 percent who do not receive early prenatal care are the poor, the uninsured and racial minorities. Women in these groups are also likely to make fewer than the recommended number of visits for prenatal care.^{10, 11}

Health Education and Counseling

There are more data on counseling for smoking than for other risk factors. Audits of patient charts show about 63 percent of smokers advised by physicians to stop smoking.¹² With regard to other lifestyle factors, surveys of family physicians indicate dietary counseling is provided to about 58 percent of those at risk, and exercise counseling for sedentary individuals to about 25 percent.¹³

⁸ Diane M. Makuc, Virginia M. Freid and Joel C. Kleinman, "National Trends in the Use of Preventive Health Care by Women," *American Journal of Public Health*, 79 (1) (January 1989): 21-26. (Hereafter cited as Makuc, *American Journal*.)

⁹ General Accounting Office, *Prenatal Care Medicaid Recipients and Uninsured Women Obtain Insufficient Care* (September 1987).

¹⁰ General Accounting Office, Human Resources Division, *PRENATAL CARE Medicaid Recipients and Uninsured Women Obtain Insufficient Care* (Washington, D.C.: 1987), chap. 2.

¹¹ The Alan Guttmacher Institute, *The Financing of Maternity Care in the United States* (New York: 1987), 30-32.

¹² Lewis, *Implementing Preventive Services*, 9-15.

¹³ Lewis, *Implementing Preventive Services*, 9-15.

FACTORS IN UTILIZATION

As the utilization data suggest, income, education and minority status are often correlated with failure to receive health care, including preventive services. Financial access, in particular, has been cited as critical. Two studies analyze receipt of preventive services with particular attention to costs and availability of third-party payment for services.

Woolhandler and Himmelstein examined data from the 1982 National Health Interview Survey to explore the relationships between insurance coverage and receipt of blood pressure check-ups, clinical breast examinations, and Pap smears by middle-aged women. Screening was deemed inadequate if it did not meet published guidelines for optimal frequency. Eighty-eight percent of the sample were adequately screened for hypertension, and 62 percent for breast cancer. For 73 percent of the women, Pap tests were adequate. The investigators found that the poor and the uneducated were least likely to be screened and black women were more likely to be screened. However, in all subgroups, lack of insurance was the strongest predictor of receipt of preventive services. The authors concluded that because the socioeconomically disadvantaged who make up most of the uninsured are at particularly high risk for preventable illness, inadequate insurance coverage leads to reverse targeting of preventive care. That is, those who would benefit most are least likely to receive it.¹⁴

The second study, by Nicole Lurie et al., looked at whether insurance coverage was an important determinant of the amount of preventive care received by enrollees during a 3-year period in the Rand Health Insurance Experiment (HIE). The HIE was a trial of cost sharing on the demand for health services; participants were assigned to either free care or one of several levels of cost sharing. The participant population was considered to be a representative sample of the U.S. population under age 65. The population was broad enough to enable the investigators to look at how different age groups used a range of recommended preventive services.

This study showed that enrollees in the HIE received far fewer preventive services than recommended. Only 45 to 60 percent of young children received timely immunizations. Seven percent of the children received no well child care in their first 18 months of life. Only 2 percent of the women aged 45 to 64 received mammography. One percent of the

¹⁴ Steffie Woolhandler and David U. Himmelstein, "Reverse Targeting of Preventive Care Due to Lack of Health Insurance," *Journal of the American Medical Association*, 259 (19) (May 20, 1988): 2872-2874.

adults received preventive sigmoidoscopy. The most frequently performed screening procedure was Pap smears, provided to 57 percent of the middle-aged women and to 66 percent of younger women.

Cost sharing was associated with reduced use of preventive services. Fifty-nine percent of the children in the free plans received some immunization compared to 49 percent of the children in the cost sharing plans. Sixty-five percent of the middle-aged women in the free plan received Pap smears compared to 52 percent of the women in the cost sharing plans. Although cost sharing affected utilization, even enrollees in the free plan did not receive all recommended services. Therefore, the researchers concluded that cost sharing is not the only obstacle to receipt of preventive care.¹⁵

Non-financial obstacles to preventive care may rest with the attitudes and knowledge of either the physician or the patient or with the health care delivery system that affects them both.

A variety of explanations have been offered for physicians' failure to offer preventive services. Some physicians who see themselves primarily as healers may offer less preventive care, concentrating on the greater challenge of managing disease rather than maintaining health. Also, curative treatment may be felt more satisfying because it yields visible short term results rather than the uncertain outcomes of preventive care. These views may be reinforced by a lack of emphasis on prevention in medical training. Attitudes toward patients may also play a part, with physicians less likely to offer service if there is skepticism about the patient's interest, willingness to pay for the service, or willingness to comply with advice.¹⁶

A physician may feel uncertain about his knowledge of effective counseling techniques or about the efficacy of a specific preventive service. When knowledge is not lacking, the physician establishes a priority for the most needed service to be provided. As stated by McPhee and Schroeder, "the public health benefit derived from giving a 50 year old man his sixth (lifetime) tetanus immunization . . . is insignificant when compared to the benefits from encouraging smoking cessation, detecting hypertension, or screening for hypercholesterolemia" ¹⁷

One frequently offered explanation for physicians' failure to provide preventive services cites the uncer-

tainties regarding the efficacy, frequency and side effects of preventive services. The argument states, if experts do not agree, then a practicing physician cannot be expected to have either the knowledge or the commitment necessary to providing a service. Tests have not supported this argument. In a study of the factors related to vaccinating elderly patients against influenza, McKinney and Barnas found no relationships between physicians' knowledge of the vaccine's efficacy or side effects and the decision to offer vaccine. In this study, only 41 percent of the patients eligible to receive the vaccine actually received it. Offers of vaccine were made most often to patients who had been vaccinated in the previous year. The authors also cited a report of a nursing home population in which only 33 percent of the residents were immunized even though the attending physicians expressed strong convictions in favor of immunization.¹⁸

Patients may not be inclined to seek preventive care that entails behavioral changes related to smoking, diet or exercise. Preventive care may be avoided because of the discomfort, inconvenience or fear of side effects. Failure to actively seek prenatal care or immunization for children may result from lack of awareness of the potential benefits. Similarly, patients may be unaware of standards for care that require that some procedures be done on a regular basis.

Systemic barriers that affect both providers and patients include lack of third-party reimbursement for preventive services, especially counseling, and a lack of system-generated cues for timely action.

COVERAGE OF PREVENTIVE SERVICES

Insurance coverage of preventive services has historically been very limited. Private health insurance plans and Medicare have generally denied payment for services not medically necessary for the diagnosis and treatment of illness or injury. Medicaid, the Federal-State program for low-income individuals, has been an exception in offering substantial benefits for preventive services. More recently, some private health benefit plans have begun to add such benefits, and a few preventive services are now eligible for Medicare reimbursement. This section reviews the current preventive service provisions of public and private health insurance programs, as well as other

¹⁵ Nicole Lurie, et. al., "Preventive Care: Do We Practice What We Preach?" *American Journal of Public Health*, 77 (7) (July 1987): 801-804.

¹⁶ Lewis, *Implementing Preventive Services*, 9-15.

¹⁷ Stephen J. McPhee and Steven A. Schroeder, "Promoting Preventive Care: Changing Reimbursement Is Not Enough," *American Journal of Public Health*, 77 (7) (July 1987): 780-781.

¹⁸ W. Paul McKinney and Gary P. Barnas, "Influenza Immunization in the Elderly: Knowledge and Attitudes Do Not Explain Physician Behavior," *American Journal of Public Health*, 79 (10) (October 1989): 1422-1424.

sources of funding for preventive services, such as Federal grant programs.

It should be noted that some preventive services may be reimbursed under health plans even when the plans exclude such services. Many screening procedures may also be used as diagnostic techniques. The line between use of a given test for screening and use of the same test to diagnose illness may be an imprecise one. Pap tests performed for screening purposes may be reimbursed if the provider reports cervicitis as a diagnosis when claiming payment; screening mammography may be reimbursed under the reported diagnosis of chronic cystic mastitis. The extent to which preventive services are being covered in such circumstances cannot be determined.

Private Health Insurance

Preventive services have historically been excluded from private health insurance policies because the use of such services does not meet the traditional definition of an "insurable event." Insurance is based on pooling risk. Subscribers pay a premium to insure against liability for a large portion of the cost of a low-probability high cost event that will occur to only a few in the risk pool. Insurance coverage is attractive because covered events are unpredictable on an individual basis. The amount of the premium is much less than the total payment for the event but the aggregate premiums cover the costs of occurrences. Preventive services, however, are predictable along age/sex lines and can be used in some form by everyone. Consequently, the premium has to be set high enough to cover services to all subscribers, and cover profit and administrative costs to the insurer. From the insurers' perspective, then, coverage of preventive services is really prepayment and not insurance.

The general failure to cover preventive services might seem short-sighted if the provision of such services could reduce claims for more costly services in the future. The extent to which preventive care can actually produce long-term savings is discussed later in this memorandum. Given the current structure of the health insurance system, however, long-term savings may not be a consideration for insurers or employers in designing a benefit package. Insurers attempting to measure the cost-effectiveness of prevention must think in terms of costs and savings in a single policy year, because purchasers may shift from one insurer to another. If, as will be suggested below, the benefits of preventive services are not realized immediately, the insurer has no incentive to offer them. Employers' incentives may be somewhat different. If an employer has relatively low turnover of workers,

and can thus expect to be providing health benefits to the same pool of workers for many years, the employer might have a greater interest in potential long-term savings. Even in the absence of this incentive, employees may press for coverage of preventive care through collective bargaining or other means.

Thus, despite the traditional insurance treatment of preventive services, some employer health benefit plans have begun to add coverage of these services. A 1988 Bureau of Labor Statistics (BLS) survey of medium and large firms found that 28 percent of health plan enrollees were covered for routine physicals, compared to 18 percent in 1986.¹⁹ Other recent surveys also suggest that coverage of preventive services may be increasing. The Foster Higgins Health Care Benefits Survey found that 41 percent of surveyed firms offered physicals to some or all employees in 1987, compared to 24 percent in 1986.²⁰ The BLS survey also found growing coverage of other preventive services. In 1988, 31 percent of plan participants were covered for well-baby care and 29 percent for immunizations. Some plans exempt preventive services from the cost-sharing requirements applicable to other types of care. IBM, for example, will reportedly reimburse up to \$200 per year in preventive services with no deductible.²¹ Statistics on the prevalence of this practice are not available.

Health maintenance organizations (HMOs)—health insurers that provide or arrange covered services through affiliated providers instead of merely paying claims for services from any provider—have traditionally been more likely than other insurance plans to offer preventive services. The term "health maintenance organization" was coined in the early 1970s to reflect the view of HMO proponents that these plans were less costly than conventional plans because of their emphasis on preventive care. More recent evidence suggests that most HMO savings are achieved through other means, such as control of inpatient hospital services. However, coverage of preventive services remains a major distinction between HMOs and conventional plans. Federally qualified HMOs must provide as basic benefits periodic health assessments, well baby care, and immunizations.²² As of June

¹⁹ U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1986* (Washington, D.C.: June 1987).

²⁰ A. Foster Higgins & Co., *Foster Higgins Health Care Benefits Survey, 1987* (New York: 1987). The difference between the BLS and Foster Higgins figures stems from the fact that the BLS survey considers only plans offered to all full-time workers, while Foster Higgins takes into account special plans offered to executives.

²¹ Jonathan E. Fielding, "Economic and Social Determinants of Prevention in Health Care Provision in the United States," *Implementing Preventive Services, 1988*.

²² A Federally qualified HMO is one determined by the Department of Health and Human Services to meet minimum standards set forth in the HMO Act (Title XIII of the Public Health Service Act). Certain employers

1988, 76 percent of the 31 million HMO enrollees were in federally qualified plans subject to these requirements.²³ HMOs that are not federally qualified may be subject to State licensure laws that impose similar minimum benefits or may offer preventive benefits on their own (possibly because they are in competition with federally qualified plans).

The BLS survey cited earlier found that 99 percent of participants in HMOs were covered for physicals and immunizations and 98 percent for well-baby care. Coverage of these services for participants in non-HMO plans ranged from 11 percent for physicals to 15 percent for well-baby care. These figures suggest that much of the recent growth in preventive services coverage may stem from growth in the market share of HMOs, rather than from changes in conventional coverage options. Still, even non-HMO plans are beginning to offer these services to a greater extent than before.

Plans that do not generally cover preventive services may offer them for a special class of employees, such as executives. The 1989 Hay/Huggins survey of medium and large employers found that 43 percent of plans covered physical examinations only for executives, and another 6 percent had different policies for executives and other salaried employees. Only 15 percent offered coverage of physicals uniformly to all salaried employees.²⁴ (The Tax Reform Act of 1986 added a new section 89 to the Internal Revenue Code, which would have denied tax preferences to plans that discriminated in favor of highly compensated employees. This provision was repealed in 1989, but there remain some restrictions on discriminatory plans offered by self-insured employers.)

Supplemental preventive benefits may also be offered as part of a flexible benefits or "cafeteria plan," under which employees may choose among such fringe benefits as child care, legal assistance, or enhanced health benefits. A Wyatt Company survey found that 19 percent of firms offered flexible benefits in 1988. Of these, 71 percent offered as one of the optional benefits "medical care reimbursement accounts."²⁵ In these arrangements, the employer contributes a specified sum to the account, and the employee can then draw on the account to cover services not otherwise available under the employer's standard health benefit plan, such as preventive care.

A number of States have mandated that insurers cover preventive services. Fifteen States require coverage of mammograms; seven mandate preventive services for children and infants. Diabetic education is required in four States and Pap smears in two. One State mandates coverage of prenatal care. However, these mandates apply to employer health benefit plans only if the employer purchases a policy from a State-licensed insurer. An employer that self-insures, covers employees' health costs directly instead of through an insurance policy, is exempt from State mandates under the Employee Retirement Income Security Act of 1974 (ERISA). As of 1984, more than 50 percent of all employees with health insurance were in self-insured plans that were exempt from State mandates.²⁶

Federal Health Programs

Medicare—Medicare law specifically excludes coverage of preventive services, with a few exceptions. Influenza vaccine and pneumococcal vaccine are covered; vaccine for hepatitis B is covered for persons at high or intermediate risk of contracting the disease. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) added coverage of Pap smears, effective July 1990. Beneficiaries may receive a Pap smear every 3 years, or more often for persons determined to be at high risk for cervical cancer. Coverage of screening mammography was included in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), but was subsequently repealed.

As in the case of private insurance, beneficiaries who choose to enroll in HMOs may receive broader preventive service coverage. Of the 131 HMOs and competitive medical plans (CMPs) with Medicare risk contracts in December 1989, 82 percent offered routine physicals, 76 percent covered immunizations beyond those covered under Medicare, and 62 percent provided health education.²⁷

The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) required the Secretary to conduct at least five 4-year demonstration projects to determine the costs and effectiveness of providing preventive health services to Medicare beneficiaries. Six such projects are currently under way in Raleigh-Durham, Seattle, San Diego, Los Angeles, Baltimore, and Pittsburgh. Randomly selected patients are placed into either experimental or control groups. The control group patients receive their usual care, while

that offer health benefits may be required to offer an HMO option to their employees if there is a Federally qualified HMO in the area that seeks to be offered.

²³ InterStudy, *The InterStudy Edge* (Excelsior, Minn.: Fall 1988).

²⁴ Hay Management Consultants, *Hay/Huggins Benefits Report* (Philadelphia: 1989).

²⁵ Wyatt Company, *1988 Group Benefits Survey Report* (Washington, D.C.: 1988).

²⁶ Patricia McDonnell, et al., "Self-Insured Health Plans," *Health Care Financing Review*, 8 (2) (Winter 1986): 1-16.

²⁷ Health Care Financing Administration, Office of Prepaid Health Care, *Monthly Report: Medicare Prepaid Health Plans* (December 1989).

individuals in the experimental groups receive screening, immunization and counseling services. Scheduled to end early in 1991, the projects will have collected data for about 2 years. One of the potential limitations of the demonstrations is that the full effects of preventive care on costs and outcomes may not be measurable over the relatively short life of the projects.

Medicaid—Medicaid is a Federal-State matching program providing medical assistance to low income persons who are aged, blind, disabled, or members of families with children. Each State designs and administers its own Medicaid program, setting eligibility and coverage standards within broad Federal guidelines. States are required to cover preventive services for children and are permitted to cover such services for adults.

For beneficiaries under age 21, all States must provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Services include periodic health examinations, vision, hearing, and dental examinations and treatment or correction of problems noted, as well as immunizations and health education. In the year ended June 30, 1989, 32 percent of the 9.8 million Medicaid beneficiaries under age 21 received initial or periodic examinations under EPSDT. (Another 10 percent of these beneficiaries were enrolled in HMOs or other “continuing care arrangements”; utilization figures for this segment are not available.)

Coverage of preventive services for adults is optional under Medicaid law; only coverage of prenatal care is mandatory. As of 1987, 21 States included preventive services in their Medicaid plans. No further information is available about the exact nature of the services provided.

Other Federal Programs—In addition to Medicare and Medicaid, a variety of Federal programs provide funding for preventive health initiatives by State and local governments or private entities. Some of these programs include funding for actual delivery of preventive services. The most important of these programs are as follows:

- The Preventive Health and Health Services Block Grant authorized by the Public Health Service Act provides grants to States for preventive health services, including programs to detect and prevent hypertension, immunization services, serum cholesterol control projects, and screening for uterine and breast cancer.
- The Maternal and Child Health Block Grant authorized by Title V of the Social Security Act provides grants to States for a variety of health programs, including direct provision of preven-

tive and primary care services to mothers and children, health screening, immunizations, and screening of newborns for sickle cell anemia and other genetic disorders.

- The Centers for Disease Control (CDC) immunization program provides grants to State and local health agencies for operation of childhood immunization programs.
- Other CDC programs fund screening and other preventive services targeted at specific diseases, including AIDS, diabetes, lead poisoning, sexually transmitted diseases, and tuberculosis.

There are also Federal programs that support certain facilities in providing general medical care, including preventive services, to target populations. Among these programs are grants to community and migrant health centers, which provide services to low-income populations in underserved areas, and the Indian Health Service, which provides or purchases services for certain groups of Indians.

EVALUATING PREVENTIVE SERVICES

Evaluating preventive services involves determining the benefits, risks and costs of an intervention and comparing them to the benefits, risks and costs of an alternative. The alternative may be another form of intervention, or the alternative may be to do nothing and let nature take its course.

The *benefits* of prevention are reflected in reduced mortality and improved quality of life. Of course, improved health, or any savings from averted costs of treatment, does not occur for every person who receives a preventive intervention but only for those who would have been afflicted with the target condition in the absence of the intervention. (Others, may, however, have greater peace of mind as a result of preventive services.) For society, the benefits appear in lower incidence of illness and in improved health status indicators.

The *risks* of prevention include the risks from the intervention itself, such as the risk of vaccine injury or radiation-induced cancer, or risk of misdiagnosis from a false-positive examination result. These risks are balanced against the risk of contracting the disease the intervention is designed to prevent.

The *costs* of prevention include the resource costs of the intervention and the costs of treating any complications from the intervention.

The following discussion reviews the available evidence on the benefits, risks and costs of the most frequently delivered or recommended preventive services. Recommendations for preventive services are issued by professional and scientific associations, voluntary associations, medical specialty organizations, governmental agencies and by individual professionals. The recommendations do not always agree and may even be contradictory. Differences occur because of the lack of good evidence of the effectiveness of preventive services and because of the diverse interpretations different groups give to the evidence that is available. There is a lack of research directly linking interventions to outcomes. Even where research is available, different interpretations may be used to derive recommendations for what services should be provided to whom.

The U.S. Preventive Services Task Force (USPSTF) uses explicitly structured criteria for linking evidence to recommendations and has established rules of evidence that are applied to each topic studied. Task Force recommendations rely on research documenting the efficacy and effectiveness of the intervention.²⁸

Incidence and mortality data and the recommendations included in the following were compiled by the Office of Technology Assessment and the United States Preventive Services Task Force.

Periodic Health Examinations

Historically, it has been recommended that everyone have a complete annual physical examination. The annual physical included a nearly identical battery of tests to each patient each year. The value of the annual physical has been questioned in recent years due to concerns about the efficiency and health benefits of performing the same procedures on each patient on a scheduled basis. Governmental agencies and professional societies have established or are developing recommendations either about periodic health examinations or about specific preventive services that require a physician visit. The frequency and content of periodic health examinations are determined by the patient's age, sex and medical history. Health improvement that results from the periodic examination alone, is undetermined.

Prenatal Care

Prenatal care encompasses a range of preventive, diagnostic and therapeutic services delivered with the goal of improving birth outcomes and the health of the mother. A large body of evidence supports the effectiveness of early and frequent prenatal care on reducing low birth weight and infant mortality. The costs of prenatal care are most often compared to the costs of initial intensive care and rehospitalization for the low birth weight baby. The Office of Technology Assessment has estimated savings of \$14,000 to \$30,000 for each low birth weight birth averted.²⁹

Controversy and uncertainty about prenatal care do not center around whether prenatal care is effective overall, but around timing and frequency of clinic visits and effectiveness of the components of prenatal care. Several studies have demonstrated that women at high risk for poor birth outcomes benefit more from prenatal care than women at average risk.³⁰ A panel convened by PHS reportedly recommended reductions in the numbers of visits and procedures delivered to pregnant women at moderate and low risk, and a redirection of resources to higher risk mothers.³¹

Well-Child Care

The main aspects of well-child care are immunization (discussed in the next section) and health supervision. Immunizations aside, there is little evidence of the effectiveness of well-child care. Mortality is not an appropriate outcome measure for children, and studies of morbidity and development have not been able to demonstrate that health supervision has any impact. Also, there are questions of whether good health in children is influenced more by medical care or by social and economic factors. Health supervision may have more impact on the health and development of a child at risk because of social and economic factors than on the health of the child at low risk. In any case, expert opinion advocates regular health care for children and parents may find it reassuring. This is an example of a preventive service that is intuitively valued, but for which definitive research is still lacking.³²

²⁹ Office of Technology Assessment, *Healthy Children*, 85.

³⁰ Committee to Study the Prevention of Low Birthweight, Division of Health Promotion and Disease Prevention, Institute of Medicine, *Preventing Low Birthweight: Summary* (Washington, D.C.: 1985), 21.

³¹ Janice Perrone, "PHS Panel Recommends Changes in Prenatal Care," *American Medical News* (October 13, 1989).

³² Office of Technology Assessment, *Healthy Children*, chap. 6.

²⁸ Robert S. Lawrence, "Preface to: U.S. Preventive Services Task Force," *Guide to Clinical Preventive Services*, Prepublication Copy (1989).

Immunizations

Immunization is considered a safe, effective and cost-effective method of controlling many communicable diseases.³³ However, it is not without risk. Yearly, a small number of people suffer serious injury or death from reactions to vaccines.³⁴ When an entire population is at risk of harm from a disease, risk from the preventive measure seems minimal. Thus, all children are immunized against the childhood diseases. However, when the risk of disease is very low, risk of injury from vaccine assumes a greater importance. Selecting the population appropriate to receive the preventive measure helps to balance the risks. Thus, influenza vaccine is targeted to the medically high risk population for whom a mild case of flu can be life-threatening. When it is difficult to estimate which carries the greater risk, the intervention or the disease, decisions to promote, provide, or accept a vaccine may be made on the basis of personal values.

Children in the U.S. are routinely immunized against diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, measles, mumps and rubella (German measles), and recently, *haemophilus influenzae b* (Hib). Vaccines against diphtheria, tetanus, and pertussis are administered in a single shot (DTP). Similarly, vaccines against measles, mumps and rubella are administered as the single MMR. Polio vaccinations are administered orally and are commonly referred to as OPV. The relatively new Hib protects against the Hib infection which is the leading cause of bacterial meningitis. The vaccines provide both health benefits and cost savings.^{35, 36}

For adults, the Centers for Disease Control, the American College of Physicians and the USPSTF recommend pneumococcal and influenza vaccines for persons over age 65. Hepatitis B vaccine is recommended by CDC and the USPSTF for intravenous drug users and others at special risk. Tetanus-diphtheria boosters are recommended for all adults every 10 years.

³³ U.S. Department of Health and Human Services, *Fiscal Year 1990 Justification of Appropriation Estimates for Committee on Appropriations*, (2) (Washington, D.C.: 1989), 61. (Hereafter cited as U.S. Department of Health and Human Services, *Appropriation Estimates*.)

³⁴ U.S. Congress, House Committee on Energy and Commerce, *National Childhood Vaccine Injury Act of 1986*, House Report No. 99-908, 99th Cong., 2d sess., part 1 (Washington, D.C.: Government Printing Office, 1986).

³⁵ U.S. Congress, Office of Technology Assessment, *Healthy Children: Investing in the Future* (Washington, D.C.: Government Printing Office, 1988), 135.

³⁶ U.S. Department of Health and Human Services, *Appropriation Estimates*, (2): 60-61.

Screening

If a screening procedure is to result in an improved outcome relative to conventional diagnosis after symptoms are present, the procedure should accurately detect an early stage of disease sooner than it could be detected without the screening examination and there should be an effective therapy available for treating the condition. The benefits of early detection are questionable if the condition that is the target of the screening is not treatable.

The ultimate benefits of early detection depend not only on the availability of treatment, but also on the patient's willingness to enter into and maintain the course of treatment which may entail substantial changes to lifestyle. An individual who, before screening, had no signs or symptoms of illness, may be reluctant to adhere to a difficult and costly regimen that offers the uncertain possibility of avoiding illness many years in the future.

There are some screening procedures which authorities agree should be performed on everyone even though they may not agree on the target population, the frequency with which the procedure should be performed or on the threshold for initiating treatment. There is general agreement on screening for hypertension or high blood pressure, for high blood cholesterol, and on performing Pap smears, clinical breast examinations and mammograms. Some tests not recommended for the general population may be recommended for persons who have no symptoms but who have been determined to be at high risk for the target condition because of medical history or some other reason. As these cases are generally left to the physician's discretion, the following discussions refer to persons at average risk.

Routine *newborn screenings* include those for phenylketonuria (PKU) and hypothyroidism, problems which can cause irreversible severe mental retardation if they are not treated or not treated early enough in an infant's development. Some States require screening for other metabolic diseases which have serious adverse consequences. While early diagnosis may be useful to some infants and their families, in some cases, there is no treatment for the target condition, or the benefits of early treatment are not known. When tests are performed for PKU and hypothyroidism only, savings amount to about \$93,000 for each case found and treated.³⁷ Additional tests may require collecting additional specimens at substantially higher cost.

³⁷ Office of Technology Assessment, *Healthy Children*, 106.

Hypertension, a leading factor in coronary artery disease, congestive heart failure and stroke, may affect as many as 58 million Americans.³⁸ The benefits of controlling hypertension have been well established with the greatest effects seen in reductions of cerebrovascular disease and deaths due to stroke. The American Academy of Pediatrics and the National Heart, Lung and Blood Institute recommend annual testing for persons 3 to 20 years old; they recommend tests every 2 years for adults not previously identified as having high blood pressure. Because the procedure can be performed simply during the course of a medical visit, it is reasonable to expect that no additional charge would be incurred.

High blood cholesterol is a major risk factor in coronary heart disease in men. The benefit of lowering cholesterol in women and the elderly has not been established. However, these groups account for a large portion of the population where a small benefit to large numbers may have a significant public health impact. The National Heart, Lung and Blood Institute recommends measurement of blood cholesterol in all adults at least every 5 years although the USPSTF leaves testing to the physician's discretion.

Pap smear is the principal screening test for cancer of the cervix. Each year, there are about 13,000 new cases and 7,000 deaths from cervical cancer in the U.S. Both figures represent decreases due in part to early detection and treatment. The appropriate frequency and ages for Pap test screening are controversial. With frequent testing, lesions that could be precancerous are less likely to escape detection. However, there may be a diminishing return with increasing frequency. The American Cancer Society, the National Cancer Institute, the American College of Obstetricians and Gynecologists, the American Medical Association, the American Nurses Association, the American Academy of Family Physicians and the American Medical Women's Association recommend annual Pap smears for all women who are or have been sexually active or have reached age 18. After 3 normal annual smears, the recommendations allow for less frequent testing at the discretion of a physician. The National Institutes of Health recommends Pap testing be discontinued after age 60 if previous smears have been consistently negative. The USPSTF recommends Pap smears be repeated every 1 to 3 years at the physician's discretion and discontinued at age 65 if previous smears have been consistently normal.

Breast self-examination (BSE) along with *clinical breast examination* and *mammography* are the three

screening techniques used to detect breast cancer, the leading cause of cancer deaths among women. Breast cancer accounts for over 140,000 new cases and over 40,000 deaths in the U.S. each year. The effectiveness of self-examination on mortality is not clear; the effectiveness of clinical breast exams and mammography has been demonstrated in reducing mortality among women age 50 and over.^{39, 40} However, there is uncertainty about the benefits of mammographies for women ages 40 to 49.⁴¹ Most authorities recommend or support monthly BSE, regular clinical examination, baseline mammography between ages 35 and 40 followed by annual or biennial mammograms from ages 40 to 49, and annual mammograms beginning at age 50. The American College of Physicians recommends annual clinical breast examinations starting at age 40 and annual mammograms beginning at age 50. The USPSTF limits recommendations for mammography to every 1 to 2 years for women ages 50 to 75.

Fecal occult blood testing (FOBT) and *sigmoidoscopy* are used to screen for colorectal cancer, the second most common form of cancer in the U.S. With the second highest mortality rate from cancer, colorectal cancer accounts for 150,000 new cases and 61,000 deaths per year. In addition, the condition and treatment can produce considerable discomfort and suffering.

Sigmoidoscopic tests use rigid or flexible instruments that enable the examiner to look into the rectum. These examinations may detect polyps, 5 to 40 percent of which may become cancerous over a period of 10 to 15 years. In persons with no symptoms, 1 to 4 cancers may be detected for every 1,000 sigmoidoscopic examinations. At \$100 to \$200, the sigmoidoscopic examination is relatively expensive, with the cost of screening all adults over age 50 estimated at \$1 billion per year. Risks include possible perforation of the bowel in addition to the danger of false-positives.

While some studies in which screening was a factor show reduced mortality from colorectal cancer, firm evidence that screening prevents morbidity and mortality from colorectal cancer is not available. The American Cancer Society, the National Cancer Institute, the American Gastroenterological Association, and the American Society for Gastrointestinal Endoscopy recommend annual FOBT and sigmoidoscopy

³⁹ Makuc, *American Journal*, 21-26.

⁴⁰ David M. Eddy, et al., "The Value of Mammography Screening in Women Under Age 50 Years," *Journal of the American Medical Association*, 259 (10) (March 11, 1988): 1512-1519.

⁴¹ David Eddy, et al., reviewed several studies and concluded that annual screening for 25 percent of the women in this age group would reduce deaths from breast cancer in the U.S. from 10,700 to 10,327 in the year 2000 at a cost of over \$400 million.

³⁸ U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services*, Prepublication copy (May 1989). (Hereafter cited as U.S. Preventive Services, *Clinical Preventive Services*.)

every 3 to 5 years beginning at age 50. The USPSTF reports that some experts advise against sigmoidoscopy but recommend FOBT every 2 years between ages 40 and 50 and annually thereafter. The USPSTF finds insufficient evidence to recommend for or against either screening procedure but states there are no grounds for discontinuing the practices where they are currently used.

Health Education and Counseling

The chronic degenerative diseases that are now the leading causes of death in the United States—heart disease, cancer and stroke—are related to risk factors that can be reduced by addressing personal behaviors. In counseling interventions, the patient receives lifestyle counseling related to altering risk factors. Counseling can vary from simple information and advice given by minimally trained personnel to multiple techniques used by both physicians and non-physicians.

Most of the research on health education and counseling has been in the area of smoking cessation where methods ranged from simple brief messages from physicians to combinations of printed materials, video tapes and ongoing counseling with follow-up contact. The studies report that from 2 percent to 10 percent of the participants stopped smoking, although some report much higher numbers immediately following the intervention.⁴²

With a large body of evidence linking tobacco use to the cardiovascular, pulmonary and cancerous conditions associated with significant morbidity and mortality, the public health impact of eliminating this risk factor for even a small number of people could be significant. A 1 percent reduction in the number of deaths from a disease that accounts for 100,000 deaths per year adds many more years of healthy life than a 50 percent reduction in deaths from a disease that causes 1,000 deaths per year.

⁴² Aaron R. Folsom and Richard H. Grimm, Jr., "Stop Smoking Advice by Physicians: A Feasible Approach?" *American Journal of Public Health*, 77 (7): 849-850; U.S. Preventive Services, *Clinical Preventive Services*, 193-197.

HEALTH BENEFITS FOR TREATMENT SERVICES FOR SUBSTANCE ABUSE AND MENTAL ILLNESS

Edward Klebe *

In response to your request, we have prepared the following memorandum on the design of a benefit package for substance abuse and mental health treatment services. The paper begins with background information on the populations at risk, with estimates of the numbers of persons abusing alcohol and illegal drugs and the numbers of persons with mental illness as reported by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Department of Health and Human Services (HHS). The opening section also includes estimates of the costs to society of substance abuse and mental illness, as reported by ADAMHA. The second section of the report describes the types of treatment modalities for substance abuse and mental illness currently in use, as well as the results of research into the effectiveness and cost-effectiveness of the various treatment modalities. The third section of the paper describes Federal programs for substance abuse and mental health treatment services, under the Alcohol, Drug Abuse, and Mental Health Block Grant, and the Department of Veterans Affairs (VA). The fourth section describes existing public and private insurance coverage for substance abuse and mental health treatment. This part includes information on Medicare and Medicaid coverage for substance abuse and mental health treatment services, as well as State laws mandating health insurance coverage for such treatment, and employer-based health insurance coverage, including coverage under the Federal Employee Health Benefits Program (FEHB). The final part of the paper discusses issues in considering a benefits package for substance abuse and mental health treatment.

BACKGROUND

The Population at Risk

Substance Abuse Population—Estimates of the extent of drug and alcohol abuse in the United States vary, but it seems clear that millions of persons in this country abuse such substances each year to varying degrees. In addition, although substance abuse trends in recent years appear to be on the decline, the fact remains that a significant proportion of our population are using illicit drugs and alcohol to excess and make up a substantial population at risk for treatment and rehabilitation services.

ADAMHA finances and publishes several national surveys that measure the extent of substance abuse in the United States. The 1988 National Household Survey on Drug Abuse, for instance, is the ninth in a series of national surveys first carried out in 1971 to measure the prevalence of drug use among the American household population aged 12 and over. The 1988 National Household Survey found that 7.3 percent of the household population age 12 and over (14.5 million persons) were “current” users of such illicit drugs as marijuana, cocaine, and others, i.e., they admitted to using such drugs in the 30 days before the survey was conducted. This was a decrease in 37 percent from the 23 million current users in the 1985 study. Users of any illicit drug “within the last year” declined from 37 million in 1985 to 28 million in 1988 (14.1 percent of the population group), a drop of almost 25 percent. The number of “current” users of cocaine fell by 50 percent, from 5.8 million in 1985 to 2.9 million (1.5 percent of the population group) in 1988, and those who used cocaine “within the past year” fell by a third, from 12 million to 8 million (4.1 percent of the population group).

* Memorandum prepared by Edward Klebe, Specialist in Social Legislation, Education and Public Welfare Division, Congressional Research Service, January 26, 1990.

The Household Survey reports that 106 million persons, 53.4 percent of the household population, were current drinkers of alcohol in 1988, down from 113 million in 1985. The household population age 35 and over is the largest group of current alcohol users, at nearly 57 million (51.3 percent of the group), but 25.2 percent of those in the 12–17 age group (5 million persons) report drinking alcohol beverages in the 30 days prior to the survey.¹

In addition to the information on alcohol use contained in the Household Survey, the National Institute on Alcohol Abuse and Alcoholism of ADAMHA estimates that 18 million adults 18 years old and older currently experience problems as a result of alcohol use. The problems may include such symptoms of dependence as loss of memory, inability to stop drinking until intoxication, inability to cut down on drinking, binge drinking, and withdrawal symptoms.

ADAMHA also sponsors a nationwide survey of young people entitled *Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth*. Better known as the High School Senior Survey, it has reported, annually since 1975, on the drug use and related attitudes of a representative national sample of high school seniors. The 1988 High School Senior Survey shows decreases in alcohol and drug use similar to those reported by the Household Survey. Use of marijuana, the illicit drug most frequently used by high school seniors, has declined markedly over the past decade. In 1979, half of all seniors reported some marijuana use in the year prior to the survey; in 1988, only one-third reported such use. In 1979, 36.5 percent of all high school seniors reported marijuana use in the prior 30 days; by 1988, only 18 percent reported marijuana use in the previous month. Similar trends were reported for other drug use—use of cocaine in the 30 days prior to the survey fell from a peak of 6.7 percent in 1985 to 3.4 percent in 1988. Use of alcohol also declined among this population, although alcohol use remains high. Nearly 64 percent of the class of 1988 reported using alcohol in the previous 30 days; 34.7 percent reported having five drinks or more in a row in the last 2 weeks before the survey.²

These surveys have certain limitations in measuring national alcohol and drug use in that they leave out populations some of whom could represent extensive drug and alcohol use. The National Household

Survey, for instance, includes no information on alcohol and drug use by persons not living in households, such as the homeless, military personnel living on base, and those in dormitories, hospitals, and jails. The High School Senior Survey includes no information on the alcohol and drug use of the dropout population of the high school senior age group. Despite these limitations, the various national surveys of alcohol and drug use are helpful in examining current trends in such use.

Mentally Ill Population—The chronically mentally ill population encompasses persons both in institutions and in the community who suffer certain mental or emotional disorders (organic brain syndrome, schizophrenia, recurrent depressive and manic-depressive disorders, paranoid and other psychoses, plus other disorders that may become chronic) that erode or prevent the development of their functional capacities in relation to such primary aspects of daily life as personal hygiene and self-care, self-direction, interpersonal relationships, social transactions, learning, and recreation, and that erode or prevent the development of their economic self-sufficiency.

In addition to the severely or chronically mentally ill, there is a substantial population of persons who, from time to time during their lives, suffer from less severe mental disorders or upsets in their everyday lives. While the diagnosis for such disorders may not qualify as clinical mental illnesses, they may cause sufficient upset in the life of the individual to require some short-term treatment from some facet of the health care sector, whether in the form of psychiatric or psychological care, marital counseling, or other counseling.

Opinions vary on the number of mentally ill persons in the U.S., with estimates ranging from 1 percent to 5 percent of the general population with severe mental disorders. National Institute of Mental Health (NIMH) estimates that the number of chronically mentally ill in the United States ranges from 1.7 million to 2.2 million, including 900,000 who are receiving residential services in a variety of institutional settings, including nursing homes, public and private mental or psychiatric hospitals, Department of Veteran Affairs facilities, residential treatment centers, or community mental health centers.³ Less information is available on the prevalence of less severe mental disorders. ADAMHA estimated in 1980 that 10 to 15 percent of the adult population of the U.S. suffered from all types of mental disorders, including severe

¹ U.S. Department of Health and Human Services, National Institute on Drug Abuse, of the Alcohol, Drug Abuse, and Mental Health Administration. *National Household Survey on Drug Abuse: 1988 Population Estimates*, 1989.

² U.S. Department of Health and Human Services, Alcohol, Drug Abuse, and Mental Health Administration, *Drug Use, Drinking, and Smoking: National Survey Results from High School, College, and Young Adults Populations, 1975–1988*, 1989.

³ U.S. Department of Health and Human Services, National Institute of Mental Health, Alcohol, Drug Abuse, and Mental Health Administration, *Mental Health, United States, 1987*. [Hereafter cited as *Mental Health, United States, 1987*.]

and chronic disorders such as depression and affective disorders, schizophrenia, alcohol and drug problems, and anxiety, phobia, and other neuroses.

The Cost to Society of Substance Abuse and Mental Illness

In 1981, the Research Triangle Institute prepared a report for ADAMHA on the costs to U.S. society in 1977 of alcoholism, drug abuse, and mental illness. The report divided total costs to society between "core costs" and "other related costs." "Core costs" were costs that are borne by the health care system or are indirectly related through reduced productivity as a result of premature mortality or excessive morbidity. "Other related costs" include the costs of social programs other than health programs, in addition to accident costs, and costs of incarceration.

The 1981 report estimated that the combined economic costs of alcohol, drug abuse, and mental illness in 1977 was \$106 billion—\$49.4 billion for alcoholism, \$16.4 billion for drug abuse, and \$40.3 billion for mental illness. These cost estimates were updated for 1980 at a total of \$190.7 billion—\$89.5 billion for alcohol abuse, \$46.9 billion for drug abuse, and \$54.2 billion for mental illness, and again in 1983 at a total of \$249 billion—\$116.7 billion for drug abuse, \$59.7 billion for drug abuse, and \$72.8 billion for mental illness. ADAMHA has contracted with the University of California, San Francisco to prepare new estimates of the economic costs to society from substance abuse and mental illness; the results are expected momentarily.

TREATMENT FOR SUBSTANCE ABUSE AND MENTAL ILLNESS

Substance Abuse Treatment

Treatment services for alcohol and drug abuse are provided in a variety of settings and modalities. Some forms of treatment are aimed at drug abusers only, such as in the case of methadone maintenance for heroin addicts, others for alcohol abuse only, such as treatment involving the use of the sensitizing drug disulfiram (Antabuse). Aside from such exceptions, however, similar modalities of treatment are used for both alcohol or drug abuse, and often in the same setting. Such treatment often starts with a short-term program of detoxification, which can be provided on an inpatient basis in a hospital or other residential facility or in an outpatient program. Although many

substance abusers do not receive any treatment services beyond it, detoxification is not a treatment for the substance abuse dependence as such, but is used, most often with alcohol abuse and heroin addiction, to clear the client's system of the physical remnants of the drug or alcohol. For those who choose to proceed to further care following detoxification, a variety of program modalities are available to prevent relapse and help clients remain alcohol- or drug-free.

Treatment can be provided on an inpatient basis, in such settings as detoxification and rehabilitation units in general hospitals, treatment units in public and private psychiatric hospitals, and free-standing treatment facilities. Substance abuse treatment can also be provided in an outpatient setting, in the office of a private physician or other treatment professional, in treatment units of community facilities such as community mental health center or hospital, or in free-standing outpatient substance abuse treatment facilities.

Treatment modalities in inpatient and outpatient settings include medical approaches, psychological approaches, and social-cultural approaches, or a combination of them, in providing care. The medical approach uses medications such as antidepressants, sensitizing agents such as disulfiram, and other medications to assist the patient in remaining drug-free. Psychological approaches to treatment use aversion therapy and other behavioral and nonbehavioral techniques. Social-cultural approaches to treatment focus on changing the social environment in which the drug or alcohol abuser functions. An example of this is the approach used by such groups as Alcoholics Anonymous and Narcotics Anonymous, which try to establish a whole new culture for the alcoholic or drug addict. It is not at all unusual for a drug or alcohol abuser to go through many different types and settings of treatment before achieving long-term success in becoming alcohol- or drug-free.

Most treatment for drug abuse in recent years has focused on three different modalities of treatment—methadone maintenance for opiate addiction, and therapeutic communities and outpatient drug-free programs for all types of drug abuse. Methadone maintenance is a treatment, usually outpatient, designed to help persons addicted to heroin and other opium-derivative drugs. It combines the daily administration of methadone, a synthetic opiate product that is administered orally and controls the craving for heroin in the addict, with intensive counseling and other social and medical services.

The residential drug-free program approach, includes the therapeutic community approach, the

model for which was the Synanon program in California in the late 1950s. Therapeutic communities are full-time, drug-free residential programs which provide a highly-structured, nonpermissive program of treatment. Therapy in a therapeutic community is generally a long-term proposition, often extending beyond a year in duration. Treatment features peer support and confrontation, individual and group counseling, and educational and job training when appropriate.

Outpatient drug-free programs vary widely in duration, goals, and content, but have in common that they do not use medication in treatment, they use counseling as the major form of therapy, and as outpatient programs they allow clients to live at home during the course of treatment. These outpatient programs began as a response to a need for community-based crisis centers for addicts. Many outpatient programs operate largely as drop-in "crisis" centers, while others are more structured. As with the therapeutic community, outpatient drug-free programs make extensive use of former addicts as staff counselors and therapists.

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) has for the past 3 years, under contract to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) of ADAMHA, compiled and published fiscal, client, and other service data related to substance abuse treatment activities in the States. These data apply to only those treatment units and programs in the States "that received at least some funds administered by the State Alcohol/Drug Agency."

In FY 1988, the most recent year for which data are published, the NASADAD study reported on 6,926 alcohol and/or drug treatment units which received funds administered by State alcohol and drug abuse agencies. Of the total, 1,806 were identified as alcohol units, 1,614 as drug units, and the remaining 3,506 as combined alcohol/drug units. These units in FY 1988 reported 1.2 million admissions for alcoholism and alcohol abuse treatment and 518,000 for drug abuse and dependency treatment.

Of the admissions for alcoholism and alcohol abuse treatment, 392,000 were for detoxification (79,000 in a hospital setting and 313,000 in a nonhospital setting), 182,000 were for longer term rehabilitation or residential care (19,000 in a hospital setting and 163,000 in nonhospital setting), and 549,000 were for outpatient care (33,000 in a hospital setting and 516,000 in a nonhospital setting). Of the more than half million admissions for drug treatment, nearly 96 thousand were

for detoxification (13,000 in a hospital setting, 47,000 in other residential settings, and 36,000 in an outpatient setting), 47,600 for methadone maintenance (nearly 46,000 in an outpatient program and 1,600 in a residential facility), and 357,000 in drug-free programs (7,800 in a hospital setting, 72,700 in a residential program, and 276,700 in an outpatient program).⁴

Mental Health Treatment

Treatment for mental illness is also provided in a variety of settings, both inpatient and outpatient, including the following:

A psychiatric hospital is a hospital (public or private) that is primarily concerned with providing inpatient care to mentally ill persons.

A general hospital with separate psychiatric service is a licensed hospital that has established organizationally separate psychiatric units with assigned staff for inpatient care and/or outpatient care and/or partial hospitalization to provide diagnosis, evaluation, and/or treatment to persons admitted with known or suspected psychiatric diagnoses. If inpatient care is provided in the separate psychiatric service, beds are set up and staffed specifically for psychiatric patients in a separate ward or unit. These beds may be located in a separate building, wing, ward, or floor, or they may be a specific group of beds physically separated from regular or surgical beds.

A residential treatment center (RTC) for emotionally disturbed children is a facility that is designed and operated primarily to provide mental health treatment to children and youth.

An outpatient mental health clinic is a facility that provides only ambulatory mental health services. The medical responsibility for all patients/clients and/or direction of the mental health program is generally assumed by a psychiatrist.

A mental health partial care organization is a free-standing organization offering primarily day or night partial care.

A multiservice mental health care organization is an organization that provides outpatient care and inpatient/residential treatment care in settings that are under the organization's direct administrative con-

⁴ National Association of State Alcohol and Drug Abuse Directors, Inc., *State Resources and Services Related to Alcohol and Drug Abuse Problems, Fiscal Year 1988* (August 1989).

trol. A community mental health center (CMHC) may qualify as multiservice mental health organizations for the purpose of this survey, if not part of a general or psychiatric hospital.

Mental health treatment services are also provided in the private office practices of psychiatrists, psychologists, and other providers, and general hospitals that have no separate psychiatric services, but admit psychiatric patients to nonpsychiatric units. Clinical social workers, family therapists, marriage counselors, and other counselors also provide a substantial amount of what must be described as mental health care, particularly to those suffering from less severe mental illnesses or the everyday problems of life. In addition, a substantial number of persons, receive care for such disorders from primary care physicians. Some estimates, in fact, indicate that a majority of individuals seeking care for a mental health disorder go to primary care physicians rather than to mental health specialists. The prevalence of mental illness among those seeking care in primary medical care settings has been estimated to range from 20 to 50 percent. In any case, it is estimated "that millions of individuals depend for their emotional well-being upon the primary care physician's sensitivity to emotional distress and willingness to accord it the same clinical significance as physical symptomatology."⁵

The third edition of *Mental Health, United States*, published in 1987 by NIMH provides statistical data on mental health organizations providing care in the U.S. and the numbers of patients they serve. In 1984, according to this survey, there were 280 State and county mental hospitals, 221 private psychiatric hospitals, 1,347 general hospitals with psychiatric services, 140 VA medical centers providing psychiatric care, 325 RTCs for emotionally disturbed children, 798 freestanding psychiatric outpatient clinics, 90 freestanding psychiatric partial care organizations, and 1,263 multiservice mental health organizations.

The average daily inpatient and residential treatment census for these facilities in the U.S. excluding territories for 1983 was 224,169 patients. Of this total, 116,236 were in State and county mental hospitals, 16,467 were in private psychiatric hospitals, 34,328 were in general hospital psychiatric services, 20,342 were in VA medical centers, 15,826 were in RTCs for children, and 20,970 were in multiservice mental health organizations.

The survey does not include average daily census for outpatient and partial care organizations, but does

include information on additions to such programs. Additions refer to patients admitted or readmitted to such settings or transferred from one such settings to another during a year. Each time a person is admitted or readmitted is counted separately, so there is some duplication of numbers, but the information is helpful in noting where outpatient services are provided. In 1983, in the U.S. excluding the territories, there were nearly 2.7 million outpatient additions for treatment.⁶

Existing Knowledge on Effectiveness and Cost-Effectiveness of Modalities of Treatment

Findings of research into the effectiveness of substance abuse and mental health treatment can be described as inconclusive at best. Treatment research carried out over the past two decades on various treatment settings and modalities has found at least limited effectiveness for most if not all types and settings of treatment for alcohol and drug abuse and for mental illness. Most treatments, apparently, can be shown to be effective in detoxifying and preventing relapses in some alcohol and drug abusers some of the time. Similarly, research on the various types of treatment of mental illness has demonstrated limited success with many patients in reducing symptoms and returning the patient to productive life in the community.

What treatment research thus far has been unable to do is to prove that any particular form of treatment is more effective than another, or to enable us to predict the most appropriate treatment for a specific patient at any particular time.

Effectiveness of Alcoholism Treatment—In 1983, the U.S. Office of Technology Assessment (OTA) published a report, *The Effectiveness and Costs of Alcoholism Treatment* (prepared under contract by Saxe et al, Boston University) which focused on the costs of alcoholism and alcohol abuse to the health care system and to society in general. The OTA report, in assessing the effectiveness and cost-effectiveness of the various treatment settings and modalities for alcoholism based on a review of available treatment research, concluded that "treatment is better than no treatment, but that methodological problems render it difficult to conclude that any specific treatment is more effective than any other." The report found consensus that inpatient treatment is far more expensive than other treatment options, but found no evidence to demonstrate that inpatient care for alcoholism treatment offered greater likelihood of suc-

⁵ Herbert C. Schulberg, and Ronald W. Manderscheid, "The Changing Network of Mental Health Service Delivery," [In] *The Future of Mental Health Services Research*, NIMH, 1989, 20.

⁶ *Mental Health, United States*, 1987.

cessful treatment than outpatient care. In assessing cost-effectiveness, the OTA review found "some evidence to support the hypothesis that alcoholism treatment is cost-beneficial" in that the benefits "seem to be in excess of the costs of providing such treatment." The review, however, concluded that it was difficult from the evidence available at the time "to determine the relative effectiveness or cost-effectiveness of inpatient v. outpatient treatment."⁷

The 1983 OTA report suggested that treatment reimbursement strategies that encouraged early outpatient treatment and continuing aftercare services on an outpatient basis would lead to better use of resources. The report, however, did not recommend curtailing the use of hospital programs because it was felt that there was not a sufficient supply of non-hospital based treatment programs available at that time.

In a 1988 study updating OTA's 1983 review and findings, the principal author states that in not making such a recommendation, the "hope was that encouragement of such alternatives would lead, over time, to a reduced utilization of hospitals." The 1988 study concluded that the hoped-for reduction in the use of hospital-based treatment programs had not occurred; that, in fact, there had been an increase in the use of such treatment. (Between 1980 and 1986, the number of hospital-based inpatient addiction treatment programs more than doubled, from 506 to 1,039, while outpatient programs increased only 13 percent, from 1,182 to 1,342.⁸) Further, the 1988 review confirmed the findings of the earlier report—that both inpatient and outpatient treatment have demonstrable effectiveness, but that there is "no evidence to suggest that inpatient treatment is better than outpatient treatment" and that there is a growing body of evidence to indicate that "relapse rates and other outcomes are no different as a result of inpatient v. outpatient." It concludes that "these findings have remained consistent across a variety of different approaches to treatment and across a diversity of populations. There remains little convincing evidence in favor of inpatient treatment or lengthy and intensive treatment." And because inpatient treatment programs are consistently more expensive than outpatient programs, the 1988 study further concludes is that "the clear implication of currently available data is that outpatient care is not only effective, but far more cost-effective than inpatient care."⁹

Effectiveness of Drug Abuse Treatment—Most research on drug abuse treatment until recently has focused on treatment for heroin addiction. Much of this research, on methadone maintenance programs and early therapeutic community programs such as Synanon, reported success in helping addicts to achieve abstinence from heroin. There was skepticism about such reports of success, due to flaws in much of the research, such as the lack of control groups.

In 1969, the first national comprehensive study of drug abuse treatment effectiveness was initiated as the Drug Abuse Reporting Program (DARP). This study looked at four major treatment modalities—methadone maintenance, therapeutic communities, outpatient drug-free programs, and detoxification. The major conclusion of the DARP research was that the most favorable results in terms of abstinence or reduced drug use and reductions in criminal activity were produced by treatment in the three major modalities, but not by detoxification only. All three produced similar positive outcomes. The DARP study appeared to show that length of treatment was the most effective predictor of success in treatment, whatever the modality—the clients who remained longer in treatment had the most favorable outcomes in terms of reduced drug use and criminal activity. The data suggested that treatments which lasted less than 90 days appeared to be of limited benefit, regardless of the type of treatment involved. Beyond 90 days, treatment outcomes improved in direct proportion to the length of time spent in treatment.¹⁰

A second national study of drug abuse treatment effectiveness called the Treatment Outcome Prospective Study (TOPS) was initiated in the mid-1970s. A multi-year study financed by NIDA, the project studied 10,000 drug users who entered treatment in 1979, 1980, or 1981 in 37 selected U.S. drug abuse treatment programs representing three major treatment modalities—methadone maintenance, therapeutic communities, and outpatient drug-free programs. Patients who served as study subjects were followed from the time they entered treatment, through five years after they left treatment.

The TOPS study addressed the impact of drug abuse treatment across the range of settings and for clients with varying degrees of dependence and associated programs.¹¹ The study measured the actual re-

⁷ Office of Technology Assessment, *The Effectiveness and Costs of Alcoholism Treatment*, March 1983.

⁸ Paul Cotton, "Detox Programs Called 'Wasteful.'" *Medical World News*, (December 26, 1988), 53.

⁹ Leonard Saxe and Lisa Goodman, *The Effectiveness of Outpatient v. Inpatient Treatment: Updating the OTA Report*, Working Paper, Bigel Institute for Health Policy, Brandeis University, 5. The preceding paragraphs use this paper as source.

¹⁰ D. Wayne Simpson, "National Treatment System Evaluation Based on the Drug Abuse Reporting Program (DARP) Followup Research," [In] *Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects*, Frank M. Tims and Jacqueline P. Ludford, eds. Research Monograph 51, National Institute on Drug Abuse, DHHS Publication No. 84-1329.

¹¹ Robert L. Hubbard, et al., *Drug Abuse Treatment: A National Study of Effectiveness*, 1989. This section of the paper uses this book as source.

duction of drug use as well as several indicators of the patients' success in building productive lives—decrease in criminal activity, excessive alcohol use, depression, and increase in employment. Generally, the study found that all of the modalities of treatment were effective in reducing drug use up to five years after a single course of treatment; they had a more limited measure of success in helping clients build more productive lives.

Basically, the TOPS study found that treatment resulted in substantial decreases in the abuse of both opiate drugs such as heroin and other drugs as well, but that the goal of abstinence was achieved by a relative few. Pretreatment levels of drug use declined dramatically during treatment, increased slightly immediately after treatment relative to in treatment levels, and again declined in subsequent periods after treatment. The prevalence of regular cocaine use increased slightly three to five years after treatment, while use of most other drugs continued to decline. These trends for use held for all three treatment modalities. Time in treatment, as in the DARP study, was among the most important predictors of posttreatment drug abuse for all types of drugs, particularly for heroin abuse—the longer a client spent in treatment, the better the chances for positive outcomes. In contrast to the DARP study, however, the TOPS study found the time in treatment necessary for greater success was relatively long: 6 to 12 months. Time in treatment was a less successful predictor of reduced posttreatment drug use for cocaine abusers and multiple drug abusers.

The TOPS study also looked at the cost-effectiveness of treatment and found substantial reductions in crime-related and other costs to the Nation of drug abusers as a result of treatment. The study found that the investment of \$5,000 for a year of outpatient drug-free or methadone treatment or \$15,000 to \$20,000 a year for residents of therapeutic communities—the average annual costs of treatments in the study—produced benefits that far outweighed the costs. The prevention of AIDS through reduction of intravenous drug use is another potential cost-related savings resulting from drug abuse treatment. The study concludes that the reduction in crime-related and other costs to society appears to be at least as large as the cost of providing treatment and that much of the expenditure is recovered during the time the abuser is in treatment. The study concludes that “. . . in that substantial benefits are to be gained during the treatment period in terms of reductions in criminal activity and associated costs to the nation, long-term drug abuse treatment appears to be an effective mechanism to limit the burden of drug abusers on the nation.”

The TOPS study also recommends several ways in which existing treatment efforts could be substantially improved through increased outreach and recruitment to encourage more drug abusers into treatment, better patient assessment and planning to ensure that drug abusers receive the services they need, improved counseling and increased habilitation and rehabilitation and related services, and increased efforts to ensure that clients remain in treatment for the appropriate length of time to improve chances of success and receive adequate transitional and aftercare services after treatment is completed. The report also calls for more research on the difficult problems of matching different types of clients with the particular treatment modalities and settings that are most appropriate for those clients. The question of what treatment works best for what type of client is still difficult to answer and for publicly-funded treatment programs can be a crucial issue in allocating limited resources.

One major problem that some researchers have with much drug abuse treatment research, including the DARP and TOPS studies, is that they concentrate for the most part on treatment for heroin addiction. Little is known as yet on the effectiveness of treatment for cocaine abuse and polydrug use, which are becoming increasingly dominant among drug abusers in our society. TOPS study results that showed increased use of cocaine after treatment demonstrate the difficulty of successfully treating addiction to this drug.

Effectiveness of Treatment for Mental Illness—The NIMH in 1989 published a monograph of papers from a 1987 conference on the Future of Mental Health Services Research. One of the papers included in the monograph reviews research over the past two decades into the effectiveness of services for the severely mentally ill.¹² This review classifies services effectiveness research that address similar issues or interventions about the following groups of treatments and treatment settings: inpatient milieu,¹³ length of hospital stay and early discharge, alternatives to hospital admission, and aftercare following an acute episode.

Hargreaves and Shumway's review of research into the use of milieu therapies found mixed results—little benefit with chronically ill schizophrenic patients

¹² William A. Hargreaves, and Martha Shumway, "Effectiveness of Services for the Severely Mentally Ill," in *The Future of Mental Health Services*, Carl A. Taube, David Mechanic, and Ann A. Hoffman, eds., National Institute of Mental Health, DHHS Publication No. (ADM) 89-1600, 1989. The following section of the paper uses this article as source.

¹³ Milieu therapy is defined as a "socioenvironmental therapy in which the attitudes and behavior of a treatment program and the activities prescribed for the patient are determined by the patient's emotional and interpersonal needs." The therapy "has particular meaning where functional behavior and activities are modeled in psychiatric settings," Lee Hyde, *The McGraw-Hill Essential Dictionary of Health Care*, 1988, 301.

treated in nonintensive milieus in one study, but in other studies, apparent benefits from intensive milieu therapy with nonchronic schizophrenic patients. Other studies found varying levels of effectiveness from different forms of milieu therapy with patient groups in a variety of settings.

Studies on the impact of length of hospital stay and early discharge on patient outcomes are in effect studies on the effectiveness of different forms of deinstitutionalization. One such study which followed patients who had spent varying lengths of time in inpatient treatment before discharge to aftercare in the community found that patients who were discharged after three weeks in hospital demonstrated fewer symptoms than patients who had been hospitalized for longer periods of time before release. However, intensive aftercare apparently reduced symptom levels regardless of the length of hospital stay. Hargreaves and Shumway conclude that the data suggest that clinical goals can usually be accomplished "in brief inpatient stays or in appropriately staffed residential treatment settings and supportive residences combined with day treatment, or through intensive outpatient case management. In a community lacking adequate capacity or quality in such facilities, or for patients who have insurance coverage that pays for inpatient care but not an alternative," they go on, "the clinician may be forced to substitute inpatient care, but these nonoptimal circumstances do not make extended inpatient care the treatment of choice in principle." They also found that studies consistently showed that early discharge of long-stay patients is possible if suitable community programs exist. Community placement does not always produce improvement in psychiatric symptoms, but does seem associated with improved social function as long as active treatment continues.

Studies of alternatives to hospital admission look at programs that substitute other residential care, day care, or alternatives carried out entirely in the community or in the patient's home in an attempt to avoid hospitalization in the first place. The authors found that the studies of alternatives to hospital treatment showed good consistency in their results, which they found remarkable because of various flaws in individual studies, and because the studies examined a wide variety of treatments in different settings with disparate patient groups. They found it possible to conclude from these studies that "caring for severely ill psychiatric patients in ways that avoid or shorten traditional hospital treatment is, on average, at least equally effective and may be more effective than standard use of hospital care. Well-organized services using alternatives to hospitalization can cost less, sometimes much less, without incurring offsetting social or private costs, and may provide greater improvement in

symptoms or social functioning." The authors do caution that, despite the positive results of these studies on alternatives to hospital admission, they may focus too much on crises leading to hospital admission. They also note that too few researchers have compared different alternatives to hospital admission or studied community settings in which particular mixes of strategies may be most cost-effective.

Studies of aftercare following hospitalization looked at a progression of more restrictive to less restrictive modes of aftercare, from residential settings such as community lodges and halfway houses, to day treatment, outpatient treatment, and case management. As with other techniques, the results of the studies on these alternatives are mixed. Some have been modestly effective, but others showed disappointing results. Despite the attention that case management is currently receiving in community mental health services, Hargreaves and Shumway found little research on the efficacy of the concept. They found that several demonstration projects seemed to show evidence for the effectiveness of case management, but concluded that project design limitations restricted their value. Another disappointing study found that randomly assigned case managed subjects, compared to a control group, received more services, cost more to maintain, and were hospitalized more often without showing higher scores on quality of life measures.

Hargreaves and Shumway conclude that mental health treatment services efficacy research has barely begun to "to identify the most cost-effective ways to organize entire service systems for this target population."

CURRENT PUBLIC PROGRAMS FOR SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT AND RELATED SERVICES

Federal Programs

Alcohol, Drug Abuse, and Mental Health Block Grant—The Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant, authorized under P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981, authorizes grants to States for alcohol and drug prevention, treatment, and rehabilitation programs; and for grants to community mental health centers (CMHC) for the provision of mental health services, including services for the chronically mentally ill, severely mentally disturbed children and adolescents,

mentally ill elderly individuals, and other underserved populations.

The original formula for the block grant resulted in national allocations for substance abuse and mental health programs which were approximately equal to each other, although the proportions of allocations varied from State to State. The authority for the ADMS block grant has been amended several times, most recently by the 1988 Anti-Drug Abuse Act, P.L. 100-690. Under the revised block grant authority, approximately two-thirds of the appropriation nationwide is allocated for substance abuse programs and one-third for mental health services activities. In FY 1988, according to NASADAD, a total of 4,786 alcohol and/or drug treatment units received block grant funds from their States. These treatment units, which also receive financial support from other sources such as State, county, and other local agencies, and from other sources such as client fees and private health insurance, admitted nearly 1.2 million clients for treatment during that year.

The total FY 1989 appropriation for the ADMS block grant was \$805.6 million, from an authorization level for the year of \$1.5 billion. In FY 1990, approximately \$1.1 billion will be available for allocation among the States, an estimated \$237.6 million for mental health activities and \$895.6 million for substance abuse activities.

Department of Veterans Affairs—The VA operates an extensive network of mental health and substance abuse treatment programs within its medical centers and outpatient clinics and related facilities. In FY 1988, over 50,000 veterans were treated in these facilities for identified drug abuse problems, over 200,000 were treated for alcohol abuse problems, and over 214,000 were treated for mental health problems. The VA in FY 1988 operated 56 drug treatment inpatient programs with 965 beds, 66 drug treatment outpatient programs, and 35 methadone maintenance programs. For alcohol abuse treatment, it operated 128 inpatient programs with 3,500 beds and 139 outpatient treatment programs. For mental health treatment, the VA operated 22,169 psychiatric beds in its various facilities in FY 1988.

EXISTING COVERAGE FOR SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT UNDER PUBLIC AND PRIVATE HEALTH CARE FINANCING PROGRAMS

Public Health Care Financing

Medicare—Medicare provides limited services for the mentally ill and for substance abusers over the age of 65, and for those who have been on SSDI for at least 24 months. Medicare services are primarily limited to inpatient services, reimbursed under part A of Medicare. Medicare does not provide a specific benefit for treatment of alcoholism or drug abuse, but services are covered which are medically necessary and available in a covered setting. Coverage for such treatment is available in both general and specialty hospitals, such as psychiatric hospitals. Medicare pays for treatment in short-term acute care hospitals for mental health or substance abuse services under its prospective payment system (PPS), while psychiatric hospitals and qualified distinct part psychiatric units in general hospitals are exempted from PPS and continue to be reimbursed on a reasonable cost basis subject to annual rate of increase limits. Medicare coverage of inpatient care furnished in a psychiatric hospital, for mental health or substance abuse services, is limited to 190 days during a person's lifetime. In FY 1985, Medicare part A benefits for mental health services totalled \$1.3 billion, of which \$252 million represented payments to psychiatric hospitals.

Part B of Medicare, until FY 1987, recognized, for purposes of reimbursement for outpatient mental health services, a maximum of 62.5 percent of \$500 of such charges in a year, or \$312.50, and would reimburse 80 percent of this amount, or \$250 a year. Under OBRA87, the outpatient reimbursement limit was increased. For each year after FY 1988, part B would recognize the lesser of \$1,100 a year or 62.5 percent of expenditures during that year. Under OBRA89, the outpatient reimbursement limit of \$1100 a year was eliminated; the coverage limit of 62.5 percent of total outpatient expenditures in a year still applies, again with the beneficiary responsible for 20 percent of that total. Thus, Medicare still pays 50 percent of total expenses for outpatient mental health services. Originally, coverage for mental health services under part B of Medicare was limited to services provided by or supervised by a physician; OBRA87 included reimbursement, as of July 1, 1988, for therapy provided by a clinical psychologist in a rural health clinic or community mental health center. Under OBRA89, coverage was extended to services

of clinical psychologists and social workers without regard to location. Under accepted medical references that have classified alcoholism as a mental disorder, the limitations that apply under Medicare to mental health services have been applied also to treatment for alcoholism. Such restrictions include the 190 days limit on the lifetime number of days of coverage available for inpatient care in a psychiatric institution, as well as the dollar limit on reimbursement of outpatient treatment services. In addition, coverage is permitted only for care that represents "active treatment." In FY 1985, Part B expenditures for mental health services subject to the limit totalled \$180 million.

Medicaid—Medicaid is a major source of funding for services for the mentally ill. State Medicaid programs, may, at their option, cover services in two types of institutional mental health providers: "institutions for mental diseases," or IMDs, and inpatient psychiatric hospitals. Services in IMDs may be covered only for beneficiaries aged 65 and older, while services in inpatient psychiatric hospitals may be covered only for beneficiaries under age 21. Beneficiaries who are under 21 at the time they enter such a facility may continue receiving care until they reach age 22. In FY 1986, an estimated \$1.1 billion in Medicaid funds was spent on these institutional mental health services for nearly 52.8 thousand beneficiaries.

Medicaid beneficiaries between age 22 and 65 may receive services for mental illness in hospitals and nursing facilities that are not IMDs or psychiatric hospitals. It is not possible to provide data on the extent of this coverage as Medicaid data do not distinguish expenditures for treatment for mental as opposed to physical problems by providers other than mental institutions.

Medicaid also covers mental health services for its beneficiary population in a variety of outpatient settings. Coverage limits for such services vary from State to State. In 1984, for instance, services in mental health clinics were covered by 44 States. Clinic providers in those States may include State or county facilities, some of them also funded through the ADMS block grant, as well as private providers. States also cover mental health services furnished in hospital outpatient departments. In a number of States, outpatient mental health services may include "partial hospitalization" or "psychiatric day care" programs. These provide services in a structured setting for part of the day for patients living in the community. Some States cover comparable programs furnished by mental health clinics.

In most States, Medicaid beneficiaries may obtain services from psychiatrists under the same rules that apply when they obtain services from physicians in other specialties. Beneficiaries may also receive some mental health care from physicians who are not psychiatrists. For reasons relating in part to State reimbursement and coverage policies, however, many psychiatrists have been reluctant to participate in the program.

Only a few States cover the services of other types of mental health professionals. Clinical psychologists were covered in 21 States in 1984, but only three covered any other type of professional, such as clinical social workers or psychiatric nurses. Some States may pay for services furnished by psychologists or other mental health professionals if they are providing services under the direct supervision of a physician, either in the physician's office or in a clinic setting.

Some States also cover alcohol and drug abuse treatment services in their Medicaid programs. A 1984 State survey found 10 such States, including 7 (Connecticut, Florida, Georgia, Kentucky, Louisiana, North Carolina, and South Dakota) which provided services in community mental health centers and/or clinics. Three other States, Washington, Minnesota, and Wisconsin also reimbursed for alcohol and drug abuse treatment services under the following categories: inpatient hospital, physician services, and non-physician services, respectively.

Private Health Insurance

State Laws Mandating Health Insurance Coverage for Substance Abuse and Mental Illness—Because of the traditionally limited coverage for treatment of substance abuse and mental illness in the private insurance marketplace, State governments in recent years have been asked to exercise their regulatory authority over the insurance industry and require the expansion of such benefits. Starting in the early 1970s, a number of State legislatures began enacting legislation to require benefits for alcohol, drug abuse, and mental health treatment to be covered by health insurance available in the State. Other State legislatures enacted less stringent versions of such legislation to require only that health insurers offer such benefits to the policyholder at his option.

A 1986 survey of State laws regulating private health insurance benefits for mental health and substance abuse found that 14 States had statutes mandating insurers to pay for mental health care in group insurance policies, some of these States also man-

dated coverage in individual policies as well. Twelve States required only that insurance policies “offer” such coverage at the policyholder’s option. Three States had laws with both mandatory and optional provisions.

The 1986 survey found 35 States which had passed legislation requiring insurers either to provide benefits for alcoholism and drug abuse treatment services or to offer such coverage. Twenty-two States had mandatory coverage laws. These coverage laws are not uniform and mandate a wide variety of benefits; some States combine a mandate with an option, such as inpatient coverage might be mandated, while outpatient coverage might only be offered. Twenty-one States chose to require health insurers to make coverage available for substance abuse services. Different States mandate coverage of varying numbers of days of inpatient hospital coverage for mental illness or for substance abuse treatment—30 to 70 days a year for inpatient mental health treatment, and from 3 to 21 days for detoxification, and from 10 to 45 days for inpatient substance abuse treatment. States also mandate coverage of varying numbers of outpatient treatment days, and provide for different limits of dollars of coverage.¹⁴

Private Employer-Based Health Insurance Coverage—A BLS survey of employee benefits in medium and large firms in 1988 describes mental health and substance abuse treatment coverage in employee health insurance benefits. The survey found that mental health coverage, although available to nearly all participants, was commonly subject to special limitations. The BLS found that 71 percent of participants in plans with mental health benefits had more restrictive hospital coverage for mental illness than for other illnesses—up from 61 percent in 1986 and 43 percent in 1982. Plans generally limited the duration of hospital stays, often to 30 or 60 days per year for mental illness, compared to 120, 365, or unlimited days for other illnesses; and sometimes they imposed a separate, lower, maximum on covered hospital expenses, such as a lifetime maximum of \$50,000 on all mental health benefits.

Plans had even more restrictive coverage for mental health care outside the hospital (psychiatric office visits). Such special limits affected 95 percent of participants in 1988, up from 91 percent in 1986 and 84 percent in 1982. Outpatient mental health care also was generally covered for fewer visits per year than other outpatient services, subject to special maximum

dollar limits on annual payments, and covered at a coinsurance rate of 50 percent rather than the 80 percent often paid by plans for other illnesses. Also, outpatient mental health care expenses often did not count toward the maximum out-of-pocket expense limitation, and the reimbursement for these expenses did not increase to 100 percent if the out-of-pocket expense limitation was met, as with other services.

The BLS survey of private employee benefits in 1988 found that alcohol and drug abuse treatment benefits covered 80 and 74 percent of health care participants, respectively. Treatment covered under substance abuse care included detoxification and rehabilitation. Ninety-five percent of all participants with some form of alcohol abuse benefits were covered for inpatient detoxification, and 78 percent for inpatient rehabilitation. As detoxification is generally considered medically necessary, nearly all plans that cover alcohol abuse treatment benefits cover it. There is a greater tendency, according to the BLS survey, to exclude inpatient rehabilitation, since it requires less constant, immediate care. Outpatient alcohol abuse treatment, generally for rehabilitation services, was available to 84 percent of participants with alcoholism coverage. Coverage patterns for drug abuse benefits were similar.

As with mental health coverage, plans were more restrictive in covering substance abuse treatment than other illnesses. It was more likely, however, for inpatient detoxification to be treated the same as other conditions than inpatient rehabilitation or outpatient care. Slightly more than two-thirds of participants with inpatient alcohol detoxification care had their coverage either subject to separate limitations or to the same limitations as for mental illnesses. This contrasts with inpatient rehabilitation and outpatient care, where about four-fifths of participants had their coverage subject to separate limitations or covered the same as mental health care.

Separate limitations for substance abuse treatment most commonly included restrictions on the number of days of inpatient hospital care per year, the number of outpatient visits per year, and maximum dollar amounts of benefits per year or per lifetime. Limitations on days and dollars were often combined for alcohol and drug abuse care. A typical limitation on inpatient care was 30 days a year. Similarly, outpatient care might be restricted to 20 or 30 visits per year.¹⁵

¹⁴ Intergovernmental Health Policy Project, *State Laws Mandating Private Health Insurance Benefits for Mental Health, Alcoholism, and Drug Abuse*, State Health Reports: Mental Health, Alcoholism, and Drug Abuse (January 1986).

¹⁵ Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1988*, BLS Bulletin 2336 (August 1989), 39 and 40.

Federal Employees Health Benefits Coverage—As with health insurance available to State and local public employees and to workers in the private sector, substance abuse and mental health benefits available to Federal employees under the Federal Employees Health Benefits Program are generally subject to special limitations. According to the *Checkbook's Guide to 1990 Health Insurance Plans for Federal Employees and the American Psychiatric Association's Coverage Catalog*, virtually all plans available to Federal employees treat inpatient mental health care, including, in most cases, inpatient treatment for alcoholism or drug abuse, differently from other hospital care. Coverage limitations include fewer days of hospitalization covered in full and a lower ceiling on covered inpatient expenses than for other illnesses. Similar limitations apply to coverage for alcohol and drug abuse inpatient treatment as well as for outpatient services for all three conditions.¹⁶

ISSUES IN CONSIDERING A BENEFIT PACKAGE FOR SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

Mental illness and substance abuse are often chronic disorders requiring periodic use of treatment services over a long period of years. At the present time, it is clear that there is no agreement on treatment modalities and settings for these disorders and little uniformity in benefit structures among third-party payers for substance abuse and mental health treatment services. Persons suffering from these disorders, or with family members suffering from such disorders, who have access through their employment to health insurance are more likely, when given a choice, to select insurance coverage with the most comprehensive benefit packages for such services. Attempts by insurers to avoid incurring the costs of covering these "high risk" patients have led to the benefits limits for mental health and substance abuse treatment coverage that characterize current health insurance practice. Some would argue that establishing a basic minimum level of coverage for mental health and substance abuse treatment would eliminate the need for the limits in coverage that currently exist.

Rationale for Including Substance Abuse and Mental Health Coverage in a Benefit Package

Several issues need to be discussed in considering the design of a uniform health insurance benefit for substance abuse and mental health treatment services, the first issue being whether to include such coverage at all. The most basic argument for covering such benefits is that these disorders are illnesses for which treatment should be reimbursed on the same basis as any other illness, that providing benefits to reimburse the treatment of substance abuse and mental illness constitutes responsible and humane social policy in response to a significant public need. In addition, requiring the reimbursement of mental health and substance abuse treatment at a level more comparable to that for other illnesses could help to remove or reduce the stigma associated with these disorders and help to improve the availability of and accessibility to such services.

Some argue that the treatment of substance abuse and mental health disorders result, in the long term, in reduction in treatment for other health disorders. According to this argument, the net cost of treatment for substance abuse and mental health care would thus be reduced by the extent of savings in general medical care utilization. Reviews of research on the significance of this medical cost offset have found that such reductions did take place. One study reported that 12 of 13 studies in mental health care found reductions of 5 to 85 percent in medical care utilization subsequent to a mental health intervention and reductions of 26 to 69 percent in medical care utilization in 12 studies on alcohol abuse treatment.¹⁷ Others find the research findings on the medical cost offset of substance abuse and mental health treatment unconvincing, because of a variety of methodological limitations in the research.¹⁸

Increasing insurance coverage for substance abuse and mental health treatment would likely result in some cost-shifting from the public to the private sector. Mental health and substance abuse treatment that is not covered by private health insurance has traditionally been supported primarily by government funds. The Federal Government supports such care through Medicare and Medicaid, the Department of Veterans Affairs, and the ADMS block grant. State and local governments support and provide care through such providers as public general and psychi-

¹⁶ Walton Francis and editors of Washington Consumers' CHECKBOOK Magazine, *Checkbook's Guide to Health Insurance Plans for Federal Employees*, 1989; and Patrice Scheidemandel, compiler, *The Coverage Catalog*, American Psychiatric Association, 1989.

¹⁷ Kenneth R. Jones, and Thomas R. Vischi, "Impact of Alcohol, Drug Abuse, and Mental Health Treatment on Medical Care Utilization: A Review of the Research Literature," *Medical Care*, (17) (December 1979).

¹⁸ David Mechanic, "The Evolution of Mental Health Services and Mental Health Services Research," in *The Future of Mental Health Services Research*, NIMH, 1989, 5.

atric hospitals and other facilities. It can be argued that requiring increased benefit coverage under private health insurance would shift some of these costs to the private sector, reduce the burden of the public sector, and generally broaden the base of financial support for treatment services.

Some who oppose a required benefit for substance abuse and mental health services do so because they feel that providers of such services often reside outside the traditional health care system where there is little quality control and little hard evidence that treatment is effective. As many alcohol and drug abuse treatment programs and providers exist apart from the established health care system, this argument goes, there is little assurance that the quality of services delivered meets established levels of care in the traditional health delivery system. In addition, the fact that there is still so little agreement on the efficacy of the various treatments for these disorders makes some observers reluctant to support enhanced insurance coverage.

Others may oppose including the benefit in a package because of the nature of these disorders, feeling that the majority of the insured population do not abuse these substances and should not be forced to pay for the self-inflicted problems of those who choose to abuse alcohol and drugs. According to this argument, most members of the population use alcohol and prescription drugs moderately and responsibly, and should not be forced to pay for the consequences of alcohol or drug abuse by a minority of persons who choose to act irresponsibly. Since alcoholism and drug addiction are self-inflicted problems, the proper response to such abuse is for the person involved to moderate such behavior and stop the abuse. Insurance premiums collected from the majority of insurance subscribers should not have to be used to pay for the self-inflicted problems of a few.¹⁹

Design of a Benefit Package

If a decision is made to include substance abuse and mental health coverage in a benefit package, further issues arise on what such a benefit package should include. Should mental health and substance abuse treatment services be covered on the same basis as other illnesses, or should there be limits on coverage for such care? If it is determined that substance abuse and mental health care should not be covered on the same basis as other care, where should limits be

made—in types of providers, in numbers of days or visits of care covered, or in dollars of care covered? What kinds of cost-sharing measures, if any, should be included? What kinds of cost containment measures should be included?

There is evidence that the existence of increased third-party coverage for health services may lead to an increase in unnecessary and excessive use of such services, a phenomenon known as moral hazard. Some people, particularly those with less severe mental health disorders, will apparently use outpatient mental health services if covered by health insurance that they would not have chosen to use if they had to pay the full cost for the services out of pocket. This appears to be the case for outpatient mental health care more than for other outpatient health care services. Some argue that improving mental health and substance abuse treatment coverage and the increased use of services that may follow because of moral hazard will increase costs substantially. As a result, insurers would have to increase premiums to pay for the care to such an extent that premiums would approach the cost of care. Research seems to indicate that use of ambulatory mental health care is responsive to patient cost sharing. Low copayments with no utilization limits would likely produce significantly higher use of outpatient services and high benefit costs; a plan with a high level of patient cost sharing combined with a catastrophic ceiling produces lower use of services and lower costs.²⁰

On the other hand, research seems to indicate that inpatient mental health care is not responsive to cost sharing, but does respond to prospective payment, length of stay limits, and fixed budget reimbursement.²¹ A 1986 NIMH report suggesting modifications to Medicare's prospective payment system to cover inpatient treatment for mental illness may have value in designing inpatient coverage under a mandated benefit. This report recommended classifying patients by diagnosis, treatment, and age—"Three groups of mental illness—psychoses, organic disorders, all others—could each be subdivided by intensity of treatment. It is possible to differentiate intensive treatment from routine treatment. (Intensive treatment is typical of specialty psychiatric facilities, while routine treatment is typical of the psychiatric treatment provided in so-called scatter beds, that is, general hospital beds not located in a psychiatric unit. Further, because child and adolescent patients who receive intensive treatment appear to stay much

¹⁹ "Private Health Insurance Coverage for Alcoholism and Drug Dependency Services: State Legislation that Mandates Benefits or Requires Insurers to Offer Such Benefits for Purchase," *NASADAD Alcohol and Drug Abuse Report* (January/February 1986).

²⁰ Willard G. Manning, Jr., et al., "How Cost Sharing Affects the Use of Ambulatory Mental Health Services," *Journal of the American Medical Association*, (256) (October 10, 1986), 1933.

²¹ Thomas G. McGuire, "Financing and Reimbursement for Mental Health Services." In *The Future of Mental Health Services Research*, NIMH, 1989.

longer than other patients, age could be a defining characteristic." ²²)

Mental health and substance abuse for young people may be a matter of particular concern in designing a benefit package. Research appears to indicate that teenagers account for a larger percentage of the costs and utilization of psychiatric and substance abuse health insurance benefits than other age groups. A recent research report notes that much of the care provided adolescents is provided in hospitals, the most expensive of all treatment settings, and suggests that, in some cases, outpatient or residential programs, especially those that involve the entire family, are much less expensive and are equally or more effective for treating adolescent mental health and/or substance abuse problems. ²³

In considering coverage for treatment of mental illness and substance abuse, it would be helpful to be able to take into account what is known about the most effective ways of providing such care in designing the most efficient and cost-effective benefit package. It may be, however, that there is too little definitive information available about the relative effectiveness of various treatment modalities and settings to be useful in designing a benefit package. The mental health treatment research review cited above appears to show, for instance, that a combination of short- rather than long-term inpatient care combined with intensive aftercare services in the community, or alternative treatment in the community that avoids hospitalization completely, can be both effective and cost-effective in treating severe mental illnesses.

²² Antoinette Gattozzi, *Prospective Payment of Mental Health Care*, State Health Reports: Mental Health, Alcoholism, and Drug Abuse (April 1986).

²³ "Psychiatric/Substance Abuse Benefits Costs, Utilization Are Highest For Adolescents," *Spencer's Research Reports on Employee Benefits* (January 1990).

There is some feeling in the substance abuse treatment community that the 28-day inpatient treatment model that appears to dominate the field, particularly for alcoholism treatment, may not always be the most effective or cost-effective method of treatment. The alcoholism treatment research cited above seems to favor a short course of inpatient care combined with longer term outpatient care as a more cost-effective form of treatment than longer term inpatient care. Drug abuse treatment research has found that the longer the course of treatment the greater the chances of success. It is difficult to imagine an employer favoring the coverage, under an employee insurance package, of a course of treatment of a year or more in a therapeutic community, not only because of the cost of such treatment, but because of the additional operating costs and inefficiencies of losing an employee for a year or more. In addition, it must be noted that long-term drug abuse treatment research has concentrated on treatment for heroin addiction, and little is known as yet about its applicability to treatment for cocaine abuse.

Those without health insurance coverage for mental health care or treatment for substance abuse have traditionally had to depend on publicly-financed care in State and locally-financed facilities, inpatient and outpatient, with their flaws and limitations. With the recidivism and repeated need for treatment that is common among some alcohol and drug abusers, as well as the long-term, often life-long, care necessary for many chronically mentally ill persons, the design of any mandated benefit package would probably need to retain some limits in the courses of treatment for substance abuse that would be covered before a patient were forced to fall back on the public sector for care.

QUALITY ASSURANCE: A COMPREHENSIVE, NATIONAL STRATEGY FOR HEALTH CARE IS NEEDED *

B-237200

February 21, 1990

The Honorable John D. Rockefeller IV
Chairman, The Pepper Commission
United States Bipartisan Commission on
Comprehensive Health Care

Dear Mr. Chairman:

In response to your request of August 11, 1989, we have examined the issues that would need to be addressed in ensuring the quality of health care under any plan to expand health care coverage for the uninsured. We have assumed that the current system of multiple public and private purchasers of health care will remain in place for at least the immediate future. In addition, we have examined the adequacy of the knowledge base for structuring such quality assurance activities. However, because we believe that most of the quality assurance issues that would need to be addressed are generic, much of this report does not distinguish between quality assurance for the uninsured and for the general population.

This briefing report presents the results of our work as discussed with your staff on January 23, 1990. We begin by noting that quality is multidimensional and that we have focused our attention on the appropriateness of care and the technical and clinical aspects of quality. We also note that health care system design has important implications for quality, and we briefly describe the various levels at which quality assurance activities are currently conducted. We conclude that there is a considerable body of knowledge about, and experience with, the organization and conduct of quality assessment and assurance activities and

a growing interest in improving and expanding these activities among many of the participants, including the medical community, consumers, employers, and purchasers of care.

In keeping with this growing interest, we suggest that a comprehensive, national strategy for assessing and assuring the quality of health care is needed. We see at least four elements as essential to a comprehensive national strategy: (1) national practice guidelines and standards of care; (2) enhanced data to support quality assurance activities; (3) improved approaches to quality assessment and assurance at the local level; and (4) a national focus for developing, implementing, and monitoring a national system. The reasons we see for needing a comprehensive national approach and a brief discussion of each of its elements are contained in section 2 of this report.

Our conclusions are based primarily on the studies of health care quality assessment and assurance in a number of settings spanning the public and private sectors that we have conducted over the past few years. We have also incorporated concepts and information on quality assurance contained in published sources, including the Institute of Medicine's report entitled *Controlling Costs and Changing Patient Care?* and the Office of Technology Assessment's report entitled *The Quality of Medical Care: Information for Consumers*. Finally, we convened a meeting of experts in November 1989 for the explicit purpose of exploring these issues and have had them review a draft of this report. (See appendix I.) We have not conducted a comprehensive review and analysis of existing quality assurance programs. Any references in this report to specific quality assurance programs are examples used to illustrate particular points and do not necessarily represent the "best" programs available.

Our work was performed in accordance with generally accepted government auditing standards. We have incorporated the comments of our experts but

* This report has been furnished by the U.S. General Accounting Office at the request of the Chairman of the U.S. Bipartisan Commission on Comprehensive Health Care. It is reprinted from a GAO report of the same title, GAO/PEMD-90-14BR (Washington, D.C.: February 21, 1990).

have not requested comments from any federal agency, since none is evaluated in this work. Unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from its date. We will then make copies available to others upon request. If you have any questions or would like additional information, please call me at (202) 275-1854 or Mr. Robert York, Acting Director of Program Evaluation in Human Services Areas, at (202) 275-5885. Other major contributors to this report are listed in appendix II.

Sincerely yours,

Eleanor Chelimsky

Assistant Comptroller General

SECTION 1—QUALITY, QUALITY ASSURANCE, AND THE HEALTH CARE SYSTEM

In this section, we begin with an overview of the concept of health care quality and how we use it in this report. We draw a distinction between quality assessment and quality assurance, which is important for our discussion of the need for a national, comprehensive quality assurance strategy in section 2. We note some instances in which the design and operation of the health care system itself can influence quality quite independently of any formal mechanism for reviewing the quality of care. Finally, we briefly describe the different levels in the health care system at which quality issues may be addressed.

Quality Is Multidimensional

The quality of care is a multidimensional concept that defies simple definition. Quality encompasses many aspects of care and means different things to different people. Patients, health care providers, and purchasers may have different notions about what constitutes high-quality care.

- To patients, “getting better” (that is, the outcome of care) is probably the primary concern. In addition, having access to care that is affordable, conveniently available, and provided in a manner that respects their concerns and preferences is important. The responsiveness of the delivery system may also be important—for example, meeting patients’ individual needs for emergency

care, coordinating services, and making appropriate referrals.

- Health care providers may emphasize the decisionmaking process that underlies diagnosis and treatment, the clinical content of care, and the technical skill with which it is rendered.
- Purchasers may place greater weight on questions of cost-effectiveness, including the need for individual diagnostic and therapeutic services, the appropriateness of the setting in which care is delivered, and the frequency, timing, and duration of services.

All these views of quality are legitimate and important. However, our primary focus is on the appropriateness of medical services and their clinical and technical quality. This implies a concern for such issues as whether necessary care was provided, whether the outcome was acceptable, whether unnecessary services were provided, and whether the location of care (that is, hospital, nursing home, home, ambulatory setting, and so on) was consistent with the patient’s needs.

There are important reasons for this focus. First, and perhaps most important, providing appropriate medical care that is effective is the common denominator of the preferences of all three groups. Second, providing improved access to inappropriate care or poor-quality care is not likely to result in improved health outcomes. Third, currently available strategies for assessing and assuring quality are targeted especially to the appropriateness of care and to technical aspects of quality. As a result, focusing attention in these areas offers the greatest potential for near-term improvements in quality.

Quality Assessment Should Be Distinguished From Quality Assurance

It is important to distinguish between quality assessment and quality assurance. Quality assessment involves the use of measures of quality, based on either explicit or implicit criteria, to assess the structure, process, and outcome of care and to monitor levels of quality over time. Quality assurance goes beyond the simple assessment of quality to include its improvement. This requires identifying and confirming problems in the quality of medical care, planning interventions to lessen or eliminate the problems, monitoring the effectiveness of the interventions, and instituting additional changes and monitoring where warranted.

Quality assessment is a prerequisite to quality assurance. It can be performed by an external assessor, assuming that the information necessary to assess the medical care is available and that criteria exist for specifying the constituents of high quality. Under these conditions, potential problems with the quality of care can be easily identified.

Successful quality assurance is more difficult, since it involves either preventing poor-quality care from occurring or improving levels of quality, which frequently requires behavior change on the part of health care providers. One example of an approach to preventing poor-quality care is to require external approval of health care interventions before the care is provided. This approach works because care that is not approved is unlikely to be reimbursed and this lessens the likelihood that the presumably inappropriate care will be provided.

But such approaches apply to individual services or procedures patient by patient. They do little to encourage providers to change their behavior or to create an environment for improving general levels of quality over time. Accomplishing the latter is generally assumed to require the commitment and involvement of the health care providers whose care is under review. This involvement is particularly important in the “gray” areas of medicine where there may be uncertainty about what the proper course of treatment is and considerable variation among physicians in how they currently care for patients. If physicians and other health care providers collectively examine information on current practice patterns and determine the reasons for variation and the preferred methods of treatment, the potential payoff in terms of improving overall levels of quality is considerable.

Quality assurance systems typically concentrate on quality assessment and on the identification of the relatively small number of providers whose care is obviously unacceptable. They do comparatively little in attempting to directly improve the overall levels of quality provided by the majority of health professionals. This is more difficult to accomplish, particularly if imposed on health professionals from the outside. If we think of the performance of health care providers in terms of the bell-shaped curve of a normal distribution, the challenge is to devise a quality assurance strategy that not only deals appropriately with the outliers but also assists in moving the entire distribution to a higher level of quality.

Health Care System Design Influences Quality

Quality is potentially influenced by almost every aspect of the design and performance of the health care system. While it is important to have effective systems for monitoring the quality of care after it is provided, it is equally, if not more, important to try to “build it in” up front. In particular, having access to needed services is a prerequisite for receiving services of high quality. For example, if a program

- does not cover a range of preventive, acute, and continuing services that are needed by the eligible population, then individuals may not have access to needed services;
- does not allow adequate reimbursement for certain services, then providers may decline to provide those services and access to care may be impeded;
- has inefficient or burdensome administrative requirements, then providers may choose not to accept patients covered by that program, again curtailing access;
- has limited ability to direct patients to high-quality providers or to foster quality among participating providers, then the care patients receive may be of varying levels of quality.

Systemic issues also affect quality. For example, an oversupply of a particular medical specialty or hospital service in a given area may mean that no provider serves enough patients to develop and maintain necessary skills or that unnecessary services will be provided in order to maintain patient volume. Malpractice is another example. The fear of malpractice suits may cause some providers to give care that is not needed and, in the case of invasive procedures, put the patient at unnecessary risk. High malpractice premiums and judgments may contribute to increasing health care costs, thereby lessening access to care for some people. While a detailed consideration of these issues is beyond the scope of this report, they are nonetheless important and deserve attention. Some of them are being addressed in other studies under way at GAO.

Quality Assessment and Assurance Occur at Many Levels

Throughout the nation, many existing programs of quality assessment and assurance can provide a foundation for the review of quality under new initiatives

to expand health care coverage. Purchasers of health care have instituted quality assessment and assurance programs to fulfill their fiduciary or public accountability responsibilities to persons whose care they finance. The Health Care Financing Administration conducts quality assurance activities for Medicare through its system of Peer Review Organizations (PROs) for primarily hospital and some ambulatory care and through carriers and intermediaries for nonhospital care. The Health Care Financing Administration's annual release of hospital mortality statistics and information on the quality of care in nursing homes are additional examples of such activities. State Medicaid agencies have requirements to monitor the use of services by Medicaid recipients; this is accomplished in a number of states through contracts with the PROs. Finally, private insurers also have quality assessment and assurance systems that resemble those of Medicare and Medicaid but also vary, depending on the needs of the health care purchaser and reimbursement methods.

The approaches above to quality assurance are sometimes referred to as "external," "regulatory," or "administrative" quality assurance. Their intent is to make sure that the care for which payment is made is appropriate. There is an emphasis on utilization control, although outcomes and other aspects of quality may also be examined, as exemplified by the PRO's use of generic quality screens. The reviews of care are frequently conducted far from the site of care. While there may be some interaction with, and feedback of information to, the providers whose care is being reviewed, the providers themselves are not deeply involved in the process of review. Quality assessment is a more dominant feature of these activities than quality assurance.

The quality of care may also be monitored and influenced at the community level or within a health service area. In addition to the review of the quality or appropriateness of individual services, quality-relevant issues to be addressed include whether there is an appropriate supply and distribution of health care providers of various types and specialties, whether the volume of services provided by individual providers is high enough to maintain acceptable skill levels, and whether effective mechanisms exist to refer patients to needed services, coordinate those services, and place patients at appropriate levels of care. Because of the highly individualized and dispersed nature of health care, many communities lack a structure for making such judgments and exerting leverage on the health care system. However, there are some voluntary efforts to develop community-wide programs. For example, a plan called Cleveland Health Quality Choice, involving the physician, hospital, and business com-

munities, is committed to evaluating the quality of hospital care in the Cleveland area and directing patients to hospitals providing high-quality care. In Minnesota, the Twin Cities Voluntary Health Care Information Project is reviewing quality indicators for hospitals and health plans in hopes of assisting health care purchasers and providers in making purchasing decisions.

Finally, many health care institutions, as well as individual providers, have voluntarily implemented their own internal quality assurance programs, reflecting a commitment to what has been termed "continuous quality improvement." The Harvard Community Health Plan, for example, has developed and implemented a program to measure quality of care that generates information to be used by clinicians and managers for identifying the reasons for problems and instituting changes intended to improve the quality of care. The Park Nicollet Medical Center in Minneapolis has developed an internal system for monitoring health care outcomes, concentrating initially on patients with heart disease and arthritis. Individual hospitals have instituted similar approaches. Small physician practices, lacking an organizational structure and patient volume to warrant a structured, statistical reporting system, have nevertheless implemented ongoing quality reviews through such approaches as bringing in outside peer reviewers to review their case records and to give them feedback on strengths and areas for improvement. The key to these initiatives is that they are voluntarily and internally generated. The health professionals involved are committed to determining the levels of quality of the care they currently provide, identifying opportunities for improvement, and seeing that improvement occurs and quality is ensured.

Some health care analysts have viewed these various levels of quality assessment and assurance as being either redundant or in opposition to one another, if not actually working at cross purposes. This is particularly true when the paperwork and administrative requirements of external reviews are burdensome and are not viewed as adequately addressing and resolving true quality problems. However, there are examples of situations in which the various levels have been complementary and mutually reinforcing. And, in some instances, the presence of external review has provided an impetus for initiating internal reviews.

We believe that the important thing to note is the considerable body of knowledge about, and experience with, organizing and conducting quality assessment and assurance activities. There also appears to be growing interest in improving and expanding these

activities among many of the participants, including the medical community, consumers, employers, and purchasers of care. While this interest could be manifested in an increased regulatory burden, it could also be developed into a more balanced system of quality assurance that uses external entities to monitor overall levels of quality of care and identify potential problems. More direct interventions could be limited to instances in which serious quality problems are confirmed or when a provider's internal quality assurance mechanisms appear to have failed. The hope that a better balance between internal and external quality assurance can be achieved has shaped many of the observations and suggestions in the next section.

SECTION 2—A COMPREHENSIVE, NATIONAL QUALITY ASSURANCE STRATEGY IS NEEDED

We believe that a comprehensive, national approach to quality assurance is required. By comprehensive and national we mean that, regardless of the source of payment or individual patients' circumstances, similar individuals with similar medical needs should be assured of receiving the same type of appropriate, high-quality care. This implies that similar requirements for quality assessment and assurance should apply across all purchasers, providers, and health care settings. We begin this section by discussing why we believe that a comprehensive national strategy is needed. We then discuss the desirability of blending into a balanced national system an external quality assurance capability together with a community of health care providers who are committed to continuing self-assessment and improvement.

Finally, we describe the essential elements of a comprehensive national strategy and discuss what is needed to move from the current quality assurance environment toward a comprehensive national strategy. The elements that we see as essential are national practice guidelines and standards of care, enhanced data to support quality assurance activities, improved approaches to quality assessment and assurance at the local level, and a national focus for developing, implementing, and monitoring a national system. Although components of each element exist today, it will take time and effort to develop, implement, and refine the type of comprehensive national strategy we envision. But much of the groundwork has already been laid.

Reasons for a Comprehensive National Strategy

We believe that a comprehensive national strategy is important for several reasons. The first is equity: the intent and stringency of quality assurance requirements should not depend on whether the care is financed by Medicare, Medicaid, expanded employer mandates, or some other arrangement for coverage expansion. However, some variation or flexibility in the specific review approaches is probably warranted to account for differences in covered populations, types of services, or reimbursement methods. For example, the focus of review for a population consisting primarily of mothers and children might be different than that for predominantly middle-aged employed persons. Similarly, assessment methods for persons enrolled in a prepaid group practice might concentrate on potential quality problems associated with underuse of services, while those for persons whose care is reimbursed on a fee-for-service basis might concentrate on the potential for overuse. Nevertheless, the overall intent and stringency of review requirements should be similar.

Second, health considerations dictate a comprehensive approach. Meeting the health care needs of individuals frequently requires providing care in a variety of settings (that is, hospitals, physicians' offices, nursing homes, home health agencies, and so on) over an extended period of time. What occurs in one setting or at one time is often influenced by what occurred in a different setting at a different point in time. Thus, it is important to be able to track the contents, appropriateness, and outcomes of care for an episode of illness, regardless of when and where the care was provided or who paid for it. Most current quality assurance systems do not have this capability.

Finally, certain operational aspects of quality assessment require a comprehensive approach. For example, many judgments about quality are based on patterns of care rather than isolated instances. If one were to examine only the patients cared for by a single provider and who had a common insurer or payment source, the number of patients might not be sufficient to provide an accurate assessment of that provider's performance. However, by combining information on care provided by a single provider regardless of the source of payment, more stable profiles of care can be generated, permitting more definitive quality assessments.

The Need for Balance

In general, our view is that the quality of care emerges most effectively from an internal commitment by providers to ongoing self-assessment and quality improvement. However, an internal commitment is not sufficient. There is also a need for external entities to monitor general levels of quality, to identify areas in which improvements are needed, and to use appropriate means to get providers to change their behavior when required.

The case for continuous quality improvement has been made most eloquently by Donald Berwick of the Harvard Community Health Plan:

"Real improvement in quality depends . . . on understanding and revising the production processes on the basis of data about the processes themselves. . . . When one is clear and constant in one's purpose, when fear does not control the atmosphere (and thus the data), when learning is guided by accurate information and sound rules of inference, when suppliers of services remain in dialogue with those who depend on them, and when the hearts and talents of all workers are enlisted in the pursuit of better ways, the potential for improvement in quality is nearly boundless."¹

However, Berwick also acknowledges the need for external monitoring, noting that "politically, at least, it is absolutely necessary for regulators to continue to ferret out the truly avaricious and dangerously incompetent."²

We also believe that external reviewers have legitimate and necessary functions to serve. The primary function is overall surveillance and monitoring of the health care system. In addition, a number of developmental and technical assistance roles are essential to establishing a comprehensive, national quality assurance strategy. They include assisting providers in the development of quality measurement tools, aggregating data on quality centrally to help providers learn from each other, providing technical support and training in the principles of quality improvement, encouraging and funding studies designed to expand the knowledge base on medical care effectiveness, and specifying relevant quality review criteria.

In order to establish and maintain an appropriate balance, both internal and external quality assurance workers must do their part. External reviewers can adopt attitudes and strategies that acknowledge and encourage the efforts of individual providers to ensure that their patients receive quality care. For example, an approach that focuses on developing information on variations among providers in treating particular conditions and working with providers to reduce that

variation may be more acceptable and effective than labeling aberrant providers as "bad" and demanding that they change. Providers who demonstrate that their behavior consistently conforms to established quality standards might be reviewed less frequently or less intensively. Similarly, such providers might be given an advantage as purchasers develop contracts with selected provider groups. On the other side, it is the responsibility of providers to be attentive to new information on health care effectiveness as it becomes available and to develop and maintain programs that demonstrably lead to continuing improvements in quality.

Elements of a Comprehensive National Strategy

Practice Guidelines and Standards—We believe that national, publicly available practice guidelines and standards are an essential element of a comprehensive quality assurance system. We use the term "practice guidelines" to refer to guidelines that assist in determining how diseases, disorders, and other health conditions can most effectively be prevented, diagnosed, treated, and clinically managed. Nevertheless, the circumstances of individual patients may justify deviations from practice guidelines. The term "standards" is used to refer to a variety of either professionally or statistically derived standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the quality of health care.

The difficulties inherent in developing such practice guidelines and standards should not be understated. For example, it is important to base guidelines and standards on sound scientific evidence about the effectiveness of medical care whenever possible and to allow more flexibility and variation in medical practice when uncertainty exists. The development of practice guidelines and standards for some conditions and procedures is feasible.

However, there is general agreement that the knowledge base on the efficacy and effectiveness of many aspects of medical care is weak or nonexistent. Here, the development of guidelines and standards will require additional information on medical care effectiveness. A mechanism for the development and updating of practice guidelines and standards is needed. Other difficulties that will have to be resolved include specifying appropriate methods for developing and reviewing guidelines and standards, setting priorities for which guidelines and criteria to develop and when to update and revise existing

¹ D. Berwick, "Sounding Board: Continuous Improvement as an Ideal In Health Care," *New England Journal of Medicine*, 320, (1) (1989): 54.

² Berwick, 54.

guidelines and standards, and pilot-testing, evaluating, and disseminating the guidelines and standards.

In addition, simply developing the guidelines and making them public will not, by itself, ensure quality. For example, the *New England Journal of Medicine* recently published a study about the effect of cesarean section guidelines on the use of cesarean sections.³ Despite widespread knowledge and endorsement of the guidelines by the obstetricians in Ontario, Canada, and a belief that they had reduced their use of cesarean sections, actual rates of cesarean section changed very little after the introduction of the guidelines. However, the Maine Medical Assessment Foundation has had some notable successes in changing physicians' practice patterns with a combination of education and feedback about how their practice patterns compare to those of their peers.

More research and experimentation is needed on the effectiveness of alternative strategies for making guidelines available to physicians and encouraging them to accept them and change their behavior as needed. And the guidelines and standards will have to be incorporated into effective internal and external programs for assessing and assuring quality of care.

Finally, there has been considerable discussion about the potential for the use of practice guidelines to reduce the provision of inappropriate or unnecessary care, thereby reducing health care expenditures and possibly saving sufficient money to pay for an expansion of coverage to persons currently uninsured. This is an appealing concept. Partial estimates of potential savings range from \$139 million in Medicare Part B expenditures if guidelines were used for a set of just eight specific procedures to about \$808 million if practice guidelines for the same procedures were used by all purchasers of care. If, in addition to reductions in the inappropriate use of services, one could make reductions in the overall intensity of services, average annual savings could be \$22 billion.⁴

However, some of the estimates fail to account for the potential cost of alternative treatments that might be provided in place of procedures found to be inappropriate and the likelihood that a program intended to reduce inappropriate care would never be fully successful. Some fail to consider the possibility that the use of some practice guidelines might actually increase expenditures over the long run by increasing the number of services and procedures that are not now provided as often as they should be. For these

and other reasons, it is unclear whether potential cost savings might be obtained by using practice guidelines.

Despite the difficulties involved in developing and using national guidelines and standards, the need for them has been recognized. The Council of Medical Specialty Societies, the American Medical Association, and other provider organizations have publicly endorsed the need for the medical profession to step forward and take the lead in developing guidelines and standards. The National Leadership Commission, the Physician Payment Review Commission, the Institute of Medicine, and others have recommended that effectiveness research and guideline development be made a top priority. The Congress has created the Agency for Health Care Policy and Research within the Public Health Service

"to enhance the quality, appropriateness, and effectiveness of health care services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services." (Public Law No. 101-229, sec. 6(a))

The Agency is to accomplish this purpose by conducting and supporting a wide range of activities including research, evaluations, demonstrations, education and training, data and data base development, information dissemination, and development of practice guidelines and standards.

An Enhanced Data System—We believe that a data base that contains at least a set of minimum data elements collected on each health care encounter *regardless of purchaser or setting* and that integrates those data for analysis is an important element of a comprehensive quality assurance system. The data should include information not only on the medical care provided during the encounter but also on any judgments about quality. An enhanced data base would enable monitoring the quality of care provided to individual patients across health care settings and providers. For example, evaluating the outcome of a surgical intervention requires knowing what happened to the patient after he or she left the hospital. An enhanced data base would also allow for the profiling of individual provider practice patterns based on care paid for by all purchasers rather than a single purchaser. Currently, these types of analyses are often not possible. In addition, health and functional status information on samples of the population would be needed in order to track changes in the health of the population over time and identify variation in health outcomes and functional status among population groups or geographical areas. This would be useful in monitor-

³ S.L. Lomas, et al., "Do Practice Guidelines Guide Practice?" *New England Journal of Medicine*, 321 (1989): 1306-1311.

⁴ These particular estimates were published in a technical appendix to National Leadership Commission on Health Care, *For the Health of a Nation* (Ann Arbor, Mich.: Health Administration Press, 1989).

ing the performance of the health system as a whole and setting national health priorities.

For hospital care, it would be possible to build upon existing claims formats and fairly uniform hospital discharge data across purchasers. However, for other settings, there is very little uniformity across purchasers. An area of particular concern is the lack of experience with obtaining detailed information from ambulatory care settings and particularly from physicians' offices. For Medicare and some private insurers, diagnostic data are now included on claim forms used for ambulatory care. This will be useful but still quite minimal for quality assessment purposes. Significant attention will have to be devoted to defining an appropriate set of minimum elements for this type of health care encounter and to ensuring that the information provided is reliable and valid. The recent revision to the 1981 *National Ambulatory Medical Care Minimum Data Set* by the National Committee on Vital and Health Statistics provides a start toward specifying such a set of data elements.

Even with agreement on the appropriate data elements, the implementation of an integrated data system will not be simple. The resources required for collecting, processing, and maintaining this data base will be substantial and include both human resources and computer hardware and software. The integration of data across settings, providers, and purchasers will require the use of unique, common identifiers for providers and purchasers as well as for patients. The data coming into the system must be checked regularly to ensure their accuracy. The data will have to be organized so that all encounters for an individual patient, as well as all services provided by a particular provider, can be easily collated and analyzed. The system must also be flexible enough to accommodate the inevitable changes and improvements in data and quality assessment methods that will come with time. Safeguards for privacy and confidentiality will also need to be addressed.

An Improved System of Local Review—Our reviews of the literature as well as the results of some quality review programs leave little doubt that significant numbers of patients are currently receiving inappropriate or poor-quality care. For example, in past studies, we have cited estimates of rates of inappropriate use of surgical procedures ranging from 14 to 32 percent as well as rates of inappropriate hospital admissions ranging from 7 to 19 percent.⁵ In addition, our evaluations of current quality assurance programs suggest that those programs are not identifying signifi-

cant proportions of cases with potential quality problems. For example, SuperPRO regularly reviews a random sample of Medicare cases previously reviewed by PROs and typically questions the appropriateness of hospital admission in almost six times as many cases as the PROs.⁶ Similarly, our review of the initial screening of cases in military hospitals for occurrences indicating potentially substandard care found that many such occurrences were missed in the initial screening process.⁷

Despite the importance of continuous quality improvement strategies in the long run, our past work has shown that improvements in external quality assurance mechanisms are needed in order to achieve the goal of appropriate, high-quality medical care for all Americans. We believe that there are a number of key components for improving the conduct of quality assurance within the framework of a comprehensive, national strategy. First, the quality assurance activities need to be conducted by local review entities that are held accountable for identifying instances of poor quality and improving overall patterns of care within their geographical area. Second, the local review entities should have available a uniform set of methods for reviewing care (including practice guidelines and standards), developing and implementing interventions and reporting information on the results of reviews and interventions. Finally, a national organization is needed to develop the national guidelines and review methods and to coordinate and oversee the activities of the local review entities.

By local review entities we mean organizations that are close enough to the local health care community that appropriate recognition of the unique circumstances of the community can be made and that the type of balanced quality assurance system we advocated earlier can be fostered and maintained. The state-level PRO program is one organizational model that approximates this goal. The individual PROs are charged with ensuring that the care provided to Medicare beneficiaries is appropriate and of high quality and, at the same time, with maintaining a positive, cooperative relationship with the provider community.

Greater uniformity and effectiveness in review methods, intervention approaches, and reporting of results will be necessary in order to ensure that all patients are receiving an equally high level of quality. However, moving toward greater uniformity is not meant to imply that all reviews must be identical.

⁵ General Accounting Office, *Medicare: Improvements Needed in the Identification of Inappropriate Hospital Care*, GAO/PEMD-90-7 (Washington, D.C.: December 20, 1989), 3-4.

⁶ General Accounting Office, *Medicare*, 3.
⁷ General Accounting Office, *DOD Health Care: Occurrence Screen Program Undergoing Changes but Weaknesses Still Exist*, GAO/HRD-89-36 (Washington, D.C.: January 5, 1989).

Some flexibility is needed to tailor review methods and interventions to specific situations. For example, generally speaking, reviewing the appropriateness of a hospital length of stay would be reasonable. However, since the Medicare Prospective Payment System reimburses hospitals a set amount regardless of the length of stay, the incentive for hospitals is to release patients earlier rather than later. Therefore, the review of the appropriateness of a hospital discharge under Medicare generally focuses on the possibility that premature discharge has occurred rather than on inappropriate days at the end of the stay.

A variety of existing methods of quality assessment could serve as the core of the common review approaches. Reviews could be done prior to care being received (prospective review) that typically focus on the need for particular procedures, the appropriateness of the proposed setting (often the hospital), and the proposed length of stay. The limited information available suggests that these reviews are cost-effective.

Reviews could be done while the care is being delivered (concurrent review) and would typically focus on the need for continued care but might also address a lack of expected progress or improvement. This type of review tends to be expensive and is often limited to potentially high-cost cases.

Reviews could be done after the care is completed (retrospective reviews) that examine the process and outcomes of care based on information contained in the medical record or on the claims form. Reviews based on the medical records are relatively expensive but can address a wide range of appropriateness and quality concerns, including both overuse and underuse.

Reviews could be done of aggregate data from either claims or medical records (profiling; small area variation analysis) that focus on identifying providers who differ in one way or another from their peers in their process or outcome of care. These could be used to target both prospective and retrospective reviews.

Reviews could be done of prescription drug use, prospectively or retrospectively, that focus on ensuring appropriate use and limiting adverse reactions and also allow the targeting of educational and other interventions for both patients and providers.

Similarly, a number of intervention approaches that have been tried could serve as the basis for developing a uniform set of interventions for use by local review entities.

One approach is that of undertaking educational interventions aimed at providing the medical community with information on the appropriate uses and costs of various medical services. The evidence on the effectiveness of this approach in changing provider behavior is mixed.

Another is to provide feedback of review results to providers, either on individual cases or on aggregate practice patterns. While generally viewed as more effective than simple educational interventions, its usefulness has been limited by the unavailability of comprehensive data across purchasers and settings.

Yet another approach consists of restrictions on providers' use of particular services (such as the total number of laboratory tests) or on their practice (such as hospital or operating room privileges). Restrictions have sometimes been met with resistance and often change behavior only as long as they remain in place.

One more approach is to offer incentives (such as increased reimbursement, more patients, reduced administrative requirements) for providers to conform to particular standards of medical practice. These are being increasingly used, particularly in managed care organizations such as preferred provider organizations and health maintenance organizations.

Last, monetary sanctions can be imposed or providers can be excluded from the program (as in the Medicare program) if they provide poor-quality care and are unwilling or unable to change their practice patterns.

Additional development, experimentation, and evaluation of both assessment and intervention techniques will be needed in order to create an effective, comprehensive, national strategy.

Finally, even though some flexibility in the implementation of reviews and interventions is necessary, a common set of reporting requirements, and particularly reporting categories, will be needed in order to oversee and evaluate the quality assurance activities at a national level. One of the greatest weaknesses of the current system of quality assurance is that there is no simple way to compare information on quality of care from one program to another or to monitor changes in levels of quality over time. This is another area in which developmental work is needed.

A National Organizational Focus—We believe a national organizational focus is required to accomplish the many developmental, implementation, and evaluation tasks needed to set up and operate a comprehen-

sive, national system of quality assurance. Some of the developmental tasks have been alluded to above—supporting research on the effectiveness of medical care and developing improved quality assessment and assurance techniques. Others include developing practice guidelines and standards, uniform reporting requirements for both medical data and data on the results of quality reviews, and methods of changing provider behavior, including approaches for fostering internal quality assurance activities. Implementation will require the development and oversight of local review organizations that have the necessary tools and skills in data integration and analysis, quality assessment, and quality assurance. Finally, the national organization will also require considerable expertise in data analysis, evaluation, and management in order to integrate the information coming from the various local review entities into a national picture of health care quality, to evaluate the performance of the local review entities, and to identify areas in which greater attention to quality is needed.

The Role of Provider Accreditation and Certification

Most of the discussion of quality assurance to this point pertains to the review of care provided to individual patients. However, it is also important to review the credentials, facilities, staff, and administrative procedures of health care providers (so-called “structural” quality assurance) to determine a provider’s capability or potential for providing high quality care. While such review cannot ensure that quality care is actually provided, it is important for ensuring that at least the necessary elements for providing quality care exist and that providers without those elements are not allowed to participate.

Established accreditation or certification programs exist for hospitals, nursing homes, and many ambulatory care settings. However, one setting in which little review of this type occurs is the individual physician’s office. We believe that such review may be particularly important for physicians who do not have hospital admitting privileges and who are not part of a larger medical network through which their care might be scrutinized. For selected physicians in this category, on-site visits might be warranted to ensure that medical records are legible, integrated, and filed; that X-ray and laboratory equipment is properly calibrated, maintained, and used; and that the process of

care (as revealed through a review of patients’ records) is appropriate and high in quality.

The Importance of Consumer Education

Expanding access to care may bring some patients into the traditional health care system for the first time. They will need assistance in learning to access the system appropriately, select primary care physicians, and understand the importance of an ongoing relationship with an “accountable” provider. Providers will need assistance in working with these new patients and helping them to use the system wisely. All consumers will need assistance in using the increasingly available information on the appropriateness and quality of care to make prudent choices among providers.

Conclusion

We believe that a comprehensive national quality assurance strategy is needed in order to ensure that all Americans receive high-quality medical care. A comprehensive national strategy is important for several reasons: (1) to ensure that the treatment of individuals does not depend on how the care is financed; (2) to be able to examine the contents, appropriateness, and outcomes of care, regardless of when and where the care was provided or who paid for it; and (3) to meet the legitimate needs for information on quality of the many different actors in the health care system.

We see four essential elements of a comprehensive national strategy:

- national practice guidelines and standards of care,
- enhanced data to support quality assurance activities,
- improved approaches to quality assessment and assurance at the local level, and
- a national focus for developing, implementing, and monitoring a national system.

We believe that the basic elements necessary to move toward a comprehensive national strategy currently exist. However, additional time and resources will be required to fully develop, implement, and evaluate the components that will make the system truly effective. The understanding and cooperation of health care providers, purchasers, consumers, and policymakers are also essential.

APPENDIX I—EXPERT PANEL ON
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TO THIS REPORT

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PRIMARY CARE SERVICE DELIVERY PROGRAMS— A CRITICAL ELEMENT TO ENSURING ACCESS TO CARE

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EXECUTIVE SUMMARY

During the past twenty-five years the nation's health care system has undergone tremendous growth in resource capacity, sophistication of medical technology, and insurance coverage of the formerly uninsured. The health care system has achieved major successes: Americans are living longer, infant mortality has dropped, and even such chronic diseases as hypertension are declining. But as the health system has grown, paradoxes have emerged and gaps in access to care have actually widened. These paradoxes have left large numbers of people without access to appropriate health care either because they lack insurance, live in communities without sufficient health resources, have special needs not met by traditional medical care, or face other barriers such as race, language, or culture. As Lisbeth Schorr notes, "The way health care is organized and paid for in the United States has produced many phenomenal medical achievements but . . . within the overall success story lie hidden failures."

Financing reforms can contribute significantly to elimination of barriers to adequate health care. However, financing does not obviate the need for delivery programs. The purpose of this paper is to discuss the service delivery component of a comprehensive approach to ensure access to care and improved health status for underserved populations. The paper focuses on access to primary care—that is, first line outpatient services provided in an office or clinic by a physician

or midlevel practitioner. It also argues for the provision of a wide range of facilitating services such as community outreach, case-management of secondary and tertiary medical care, and integration of traditional medical services with health, social, and welfare services.

This paper describes barriers to the receipt of appropriate primary care, explains ways in which specific population subgroups experience these barriers, defines and evaluates the effectiveness of existing primary care service delivery programs, and finally, proposes a framework for future reform.

Barriers to Care. Nearly 32 million Americans are uninsured and many more are underinsured. In addition to financial barriers, nonfinancial barriers still prevent many people from receiving effective primary care. Specifically, 33 million persons live in Federally designated Health Manpower Shortage Areas; 16 million in isolated rural communities and 17 million in disadvantaged urban areas, where there is a dearth of health care facilities, personnel, and other resources needed for the routine provision of services at the local level. An estimated 26 million persons do not have a regular private sector primary care physician. Additionally, even if facilities and services are available, they are often fragmented (i.e., offered through multiple organizations in various locations) and poorly coordinated. Finally, there are language, racial, educational, cultural, and attitudinal differences which impose special barriers to effective delivery of health and social services.

Groups Affected by These Barriers. There are numerous population subgroups that experience barriers to the receipt of appropriate primary health care. A disproportionate share of those facing these barriers are poor and minority. Additional special population

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groups that experience particular hurdles to the receipt of care include, among others, high risk pregnant women and their infants, migrant farm workers, individuals with HIV infections, substance abusers, and the elderly. Of course many individuals fall into more than one of these population groups.

Existing Comprehensive Primary Care Programs. There are several types of subsidized service delivery programs that serve those individuals who lack a regular private sector primary care physician. At the Federal level, the Bureau of Health Care Delivery and Assistance is responsible for programs which bring community-based primary health care to approximately six million poor and underserved persons through grants and manpower recruitment. The Indian Health Service provides primary care services through a variety of urban and rural programs to over one million persons per year. Two Federal Grant programs (the Maternal and Child Health Services Block Grant, and the Preventive Health and Health Services Block Grant) help support primary care services to underserved populations, usually provided through State and local health departments. Approximately 25 percent of local health departments have gone beyond offering discrete single health services, and now provide primary care. Hospitals are the only family doctor in many areas, in that underserved persons often rely on hospital emergency rooms or organized outpatient departments as their principal source of primary care. School-based health centers offer primary health care, through 150 health centers operating in junior and senior high schools in both urban and rural areas. Finally, the private sector helps to serve vulnerable populations by subsidizing over 500 private, non-publicly funded health centers throughout the country.

Effectiveness of Existing Programs. A number of studies have shown that existing primary care programs have made significant inroads in reducing barriers to the receipt of appropriate health care, and improving health status and outcome. For example, the effectiveness of community-based health centers is evidenced by the fact that Medicaid patients who use these centers have lower hospital admission rates, shorter lengths of stay, and make less inappropriate use of emergency rooms than similar patients who use Medicaid but not a community health center. Similarly, health centers have had a beneficial effect on both white and black infant mortality rates, have reduced rheumatic fever and untreated middle ear infections, and have brought about an increase in the number of immunized children. Unfortunately, most of the research in this area was conducted in the 1970s and early 1980s.

Future Directions. Service delivery programs effectively target their services to underserved, vulnerable populations by offering an optimal continuum of activities. First, they ensure the presence of providers and facilities and offer comprehensive primary medical care. Second, they provide case management, and where possible, co-location of a broad range of health, welfare, and other support services. Third, they include outreach and other social services which foster health prevention and promotion behavior, encourage early entry into the health and social service system, and encourage at-risk populations to maintain participation in care. Examples of such services include health education programs, transportation and home visiting, on-site day care, and bilingual services. Finally, effective programs are community-based and community-responsive, addressing unique local circumstances and health care problems.

Expanding health care insurance coverage should reinforce—not replace—support for primary care delivery systems. Depending on their design, financing reforms can increase the capacity of direct delivery providers. If insurance covers patients previously uninsured or underinsured, delivery systems can then use their State, Federal or private funds to develop additional facilities, to expand types of services and the number of patients served at existing facilities, and to provide additional outreach and case management services. Thus insurance and service delivery approaches to ensuring access to care are synergistic.

THE PROBLEM—BARRIERS TO CARE

Barriers to the receipt of primary care are varied, but can generally be categorized into the groups described below. It is important to note that many individuals who lack access to appropriate health care have problems that fall into more than one of these categories.

Financial Barriers

While this paper emphasizes service delivery issues, these problems are exacerbated by financial barriers to access which limit the care available to poor people, and place added burdens on the service delivery programs that are available to this population. Indeed, 31.8 million Americans lacked health insurance, either public or private, in 1987 (the most recent year for which data is available).¹ While some are young and

¹ Bureau of the Census, *Current Population Survey* (Washington, D.C.: March 1988).

healthy (e.g., college graduates who have not yet replaced their parents' health insurance with their own), most are poor. Additionally, many other persons are underinsured—that is, their public or private insurance does not cover important services, especially preventive and primary care. For example, Medicare, which requires 20 percent patient payment for outpatient services, excludes preventive services such as Pap smears.²

Capacity/Resource Barriers

As discussed below, there are many people who lack access due to insufficient facilities, personnel, and other resources needed for the routine provision of services at the local level. In certain geographic areas—mainly rural and inner city areas, there is a dearth of health care resources and personnel. In 1988, 33 million people (17 million urban and 16 million rural) were living in Health Manpower Shortage Areas (HMSAs).³ Not all of these individuals experience access problems, but there is a great deal of overlap with the estimated 26 million persons who lack a regular private sector primary care physician.⁴

Isolated Rural Areas—Rural residents lag behind the rest of the country in access to health care. There are roughly one-half as many physicians in rural areas as there are in urban areas—97.9 vs. 174.7 per 100,000 population. Rural counties with a population of less than 10,000 had only 53 physicians per 100,000 population in 1985, and in counties with fewer than 2,500, this ratio fell to 29.9.⁵ Physician availability in rural areas is expected to worsen even further in the next few years due to an expected 25 percent rate of physician retirement and severe cutbacks in the National Health Service Corps Scholarships program, which supplies physicians to HMSAs.⁶ The Nation has 1,955 HMSAs (areas with a primary care physician to population ratio of less than 1 to 3,000), and a total of 4,224 primary care physicians is needed to bring all these areas up to the designation threshold. In 1990 there are a total of approximately 1,000 obligated NHSC physicians, of which 120 are newly available scholars. This contrasts dramatically with 1986, when

there were 2,600 scholarship obligated physicians of which 1,400 were newly obligated. Isolation, overwork, lack of professional contact and low economic viability all contribute to difficulties in attracting new providers to rural areas voluntarily.

Also, beyond personnel issues, there are other problems related to low geographic density, such as insufficient population to support facilities and modern technology. The closure or cutback of many rural hospitals affects the availability of primary care directly as well as the ability of rural areas to attract providers.

Disadvantaged Urban Areas—The 17 million urban residents living in HMSAs are primarily in the inner cities. The overall adequate or excess supply of physicians in urban regions masks problems in poor, often minority areas within them. In ten cities the number of office-based physicians per 100,000 population in poor areas declined from 136 in 1963 to 127 in 1980, while in non-poverty areas their number grew from 131 to 150.⁷

Reasons that physicians may not practice in these areas include concerns about inadequate facilities and, perhaps, a reluctance to serve the poor and minority populations concentrated there. Because of the high percentage of Medicaid and uninsured patients in inner cities, it also may be more difficult to maintain an economically viable practice in these areas. Other providers may locate their practices in urban areas but are not necessarily willing to treat the poor and minority groups.⁸

Operational/Organizational Barriers

Even if the physical/structural resources are in place, underserved populations face barriers related to the operation and organization of services—such as inadequate transportation to primary care sites, difficulties in arranging child care, unpleasant surroundings, long waiting times, inconvenient hours of operation (causing excessive time lost from work), and lack of integration among the various programs serving high-risk, hard to reach population groups.⁹

² The Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, U.S. Public Health Service, "The Bureau of Health Care Delivery and Assistance's Unique Role in Primary Care," (Washington, D.C.: December 1988), 9.

³ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 9.

⁴ L.H. Aiken, C.E. Lewis, J. Craig, R.C. Mendenhall, R.J. Blendon, and D.E. Rogers, "The Contribution of Specialists to the Delivery of Primary Care: A New Perspective," *New England Journal of Medicine* (June 4, 1979): 1363-1370.

⁵ David A. Kindig, and Hormoz Movassaghi, "The Adequacy of Physician Supply in Small Rural Counties," *Health Affairs* 8 (2) (Summer 1989): 66.

⁶ Larry S. Patton, *The Rural Health Challenge*, Staff Report to the Special Committee on Aging, U.S. Senate (Washington, D.C.: Government Printing Office, 1988), 52-53.

⁷ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 10.

⁸ President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Health Care: The Ethical Implications of Differences in Availability of Health Services*, Vol. 1: Report (Washington, D.C.: Government Printing Office, March 1983), 83-86.

⁹ Institute of Medicine, *Prenatal Care: Reaching Mothers, Reaching Infants, Summary and Recommendations* (Washington, D.C.: National Academy Press), 6-7.

Case management of primary, specialty and inpatient services combined with other social and support services can make the health care system more effective for everyone but are particularly important for the poor and underserved. Among the services needed are those relating to eligibility determinations for health financing, mental health, substance abuse, runaway youth, infant day care, child abuse and neglect, welfare programs, nutrition, family planning, housing, transportation, labor practices, correctional programs, and legal services. Although these services are typically available through multiple organizations, local agencies often lack adequate personnel, materials, or knowledge of other programs to make referrals or other coordination efforts, such as arranging for co-location of services. The problem is exacerbated in rural areas, where the physical facilities that house necessary services are geographically dispersed, thus complicating integration of service delivery. In addition, a multiplicity of eligibility requirements, and multiple sites for needs-determination procedures complicate the ability to access services. Finally, rivalries among different disciplines and organizations can fragment provider responsibility. This inability to integrate services means that those least able to do so must grapple with the most "red tape" and barriers to receiving care.¹⁰

Cultural/Social Barriers

Oftentimes, language, racial, educational, behavioral, environmental and attitudinal differences impose special barriers to effective delivery of health and social services. Health care professionals may lack necessary skills, such as language training, health education, and training in the provision of preventive services, or may be insensitive to cultural differences.¹¹ For many population groups, individual, family, and community behavior patterns can affect the pursuit of appropriate care in a timely fashion. As an example, one-third of the women in the U.S. do not receive adequate prenatal care, of which the highest proportion are black, Hispanic, poorly educated, low-income, unmarried, and/or teenaged.¹² Fear or lack of knowledge is often a barrier to care for these women, who are twice as likely as those who receive prenatal care to have a low-birth weight baby.¹³ Fi-

nally, exposure to environmental toxins or hazards, such as lead, also influence pregnancy and other health outcomes.¹⁴

HOW GROUPS ARE AFFECTED BY THESE BARRIERS

There are numerous population subgroups that experience barriers to the receipt of care. A disproportionate share of those facing the barriers described above are poor and minority. In addition, there are smaller, frequently overlapping subgroups who are disproportionately poor or minority and who also face their own unique hurdles to accessible care.

The Poor

The Robert Wood Johnson Foundation found in a recent study that lack of accessible care is largely a problem of the poor. Specifically, access to health care showed marked improvement from the 1950s to 1982, when the gap between rich and poor was closing. Unfortunately, since 1982 this gap has widened, reducing access to care among the poor. For example, the adult poor below the age of 65 had 30 percent fewer ambulatory visits per person in 1986 than in 1982. The widening gap is due to financial barriers (i.e., increasing lack of health insurance) as well as nonfinancial barriers (e.g., maldistribution of resources, logistical and lifestyle barriers).¹⁵ The impact of the nonfinancial barriers is noted by a recent study showing that among insured adults, the poor are 4.4 times as likely as those who are not poor to have needed medical services but not to have received them.¹⁶

There are approximately 32 million Americans with incomes below the poverty line.¹⁷ The poor are less likely than the non-poor to have private medical coverage or medical coverage through their workplace. One-half of the 31.8 million people who lack health insurance have incomes below 150 percent of the poverty level. Populations in this group include pregnant women and infants, children, and other uninsured per-

¹⁰ William White, consultant to the Bureau of Health Care Delivery and Assistance, Department of Health and Human Services, "Draft Report prepared for the Subcommittee on Community Based Health and Social Services, White House Task Force on Infant Mortality" (1989), 9.

¹¹ William Gorham, *Delivery of Health Services for the Poor*, U.S. Department of Health and Human Services (Washington, D.C.: December, 1967), 257.

¹² Gold, Kenney, and Singh, *Blessed Events and the Bottom Line: Financing Maternity Care in the United States* (New York: The Alan Guttmacher Institute, 1987), 14-16.

¹³ Gold, Kenney, and Singh, *Blessed Events*, 14-16.

¹⁴ Department of Health and Human Services, "Facts on Infant Mortality and Access to Prenatal Care" (unpublished information distributed on Child Health Day, Washington D.C.: 1989).

¹⁵ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 8.

¹⁶ Rodney A. Hayward, M.D., Martin F. Shapiro, M.D., Ph.D., Howard E. Freeman, Ph.D., and Christopher R. Corey, M.A., "Inequities in Health Services Among Insured Americans," *New England Journal of Medicine* (June 9, 1988): 1507.

¹⁷ Jane Koppelman, National Health Policy Forum, The George Washington University, *Poverty and the Underclass: Priorities for the Next Decade*, Issue Brief No. 511 (Washington, D.C.: 1989), 2.

sons such as the working poor, who are not eligible for Medicaid but have no private insurance. Nationwide, Medicaid reaches fewer than half the poor, and even fewer of the employed poor. In fact, fear of losing Medicaid's protection may be an incentive to remain unemployed, thus perpetuating the poverty cycle.¹⁸

Minorities

There are 60 million members of minority groups (blacks, Hispanics, Native Americans, and Asian Americans), a disproportionate percentage of whom are low income. Thus, they are likely to face access problems related to poverty, as well as additional barriers arising from location in the inner city, discrimination, and other socio-economic and cultural factors.¹⁹ For example, researchers Janet Mitchell and Rachel Shurman found that, controlling for other factors, obstetricians were less likely to participate in Medicaid in counties with high minority populations. The same was not true for surgeons or general practitioners, causing speculation as to whether it was the prospect of continuing and frequent contact with patients that led to the difference. Mitchell and Shurman also noted that many doctors have expressed a willingness to treat the poor in a public clinic or outpatient department for a few hours a week, but not in their own offices, where their private patients might be uncomfortable.²⁰

The impact of these non-financial barriers on minority populations is demonstrated by the fact that among *insured*, working age adults, blacks are 1.7 times as likely as whites to need medical services but not to receive them. Similarly, Hispanics with a medical illness are 2.2 times as likely as whites not to have seen a physician within the past year.²¹

As a result of financial as well as nonfinancial barriers to care, there are significant gaps in health status between minorities and the rest of the nation. Specifically, in virtually every measure of health status (e.g. life expectancy, death rate, infant mortality rate, and the prevalence of coronary and cerebrovascular disease), minorities, particularly blacks and Hispanics, are significantly worse off than whites.²²

¹⁸ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 9.

¹⁹ President's Commission Report, 83-86.

²⁰ Janet B. Mitchell and Rachel Shurman, "Access to Private Obstetrics/Gynecology Services under Medicaid," *Medical Care*, 22 (11) (November 1984): 1034.

²¹ Hayward, Shapiro, Freeman, and Corey, "Inequities in Health Services," 1507.

²² Office of Disease Prevention and Health Promotion, U.S. Public Health Service, U.S. Department of Health and Human Services, *Disease Prevention/Health Promotion: The Facts*, (Palo Alto, Calif.: Bull Publishing Company, 1987), 198, 202.

High Risk Pregnant Women and Their Infants

In 1988, the provisional infant mortality rate in the United States was 9.9 deaths within the first year per 1,000 live births. The rate for black infants was nearly twice that. In 1987 the black infant mortality rate (17.9 per 1,000) was at the same level as the white rate had been 25 years earlier. Although the U.S. rate is better than ever, 21 nations have lower rates.²³

There has been a troubling slowdown in the rate of decline in infant mortality observed in the 1980s. During the 1970s, the rate declined by 4.9 percent per year for whites and 4.1 percent per year for blacks. In 1987, the black infant mortality rate declined by less than 1 percent for the third year in a row. The white infant mortality rate declined by 3.6 percent.²⁴ Worse yet, in 1987, the black fetal death rate *increased* by 2.7 percent, the first increase since the 1960s. White fetal death rates decreased by only 1.6 percent.²⁵

The rate of progress has slowed primarily because factors associated with increased risk of infant death, such as low birth weight and lack of access to prenatal care, have shown no improvement in recent years.²⁶ The importance of prenatal care is demonstrated by the fact that women who get insufficient prenatal care have double the risk of having a low birth weight baby, and give birth to babies that are three times more likely to die in infancy.²⁷ In 1980, low birthweight infants represented less than seven percent of all newborns in the United States, but accounted for sixty percent of all babies who died in infancy.²⁸

Many pregnant women experience a combination of the financial, organizational, and cultural barriers described above. They are particularly affected by lack of providers, exacerbated by the fact that some physicians are no longer practicing obstetrics, in part due to the cost of liability insurance. Lack of coordination among health and social services also has a significant impact on low-income pregnant women, who are ill-prepared to visit numerous locations in search of needed services. For example, services under the Special Supplemental Food Program for Women, Infants, and Children (WIC) are often not provided in conjunction with prenatal care.

²³ White House Task Force on Infant Mortality, Draft Report, "Infant Mortality in the United States," (Washington, D.C.: October 29, 1989), 3.

²⁴ White House Task Force, Draft Report, 3.

²⁵ White House Task Force, Draft Report, 4.

²⁶ White House Task Force, Draft Report, 3.

²⁷ Office of Disease Prevention and Health Promotion, *The Facts*, 134.

²⁸ Congress of the United States, Office of Technology Assessment, *Healthy Children: Investing in the Future*, OTA-H-345 (Washington, D.C.: Government Printing Office, February 1988), 6.

Migrant Farmworkers

The nation's three million migrant and seasonal farmworkers and their families share some needs with other indigent people, but these are compounded by special hazards of farmwork, such as pesticide exposure and accidents, combined with language, mobility and other barriers to care. Migrant workers are rarely covered by Medicaid because of residency requirements or by private insurance because of the nature of their employment. They often work in rural, isolated communities where there are few providers to begin with. Those providers who are present tend to be physicians with full practices who are unable to cope with a sudden and seasonal influx of additional patients. In addition, migrants' cultures are usually vastly different from that of overburdened local providers, and they have special needs for support and facilitating services. Because of the instability of their living arrangements they are unlikely to have their health care needs met in time to prevent more serious illnesses.²⁹

Individuals With HIV Infections

According to CDC estimates, there are one and a half million persons infected with the HIV virus, with an estimated 285,000 cases of AIDS expected by 1992. GAO believes these estimates are low—that there will be 365,000 cases by the end of 1992.³⁰ This population has enormous needs that are straining the health care system. Primary care is an increasingly important component of caring for HIV infected persons and community-based resources are critical—particularly as the disease spreads to more inner city substance abusers, their sexual partners, and children. HIV infection poses substantial problems for the health care system because those infected are often times poor, in general bad health, homeless, and IV drug abusers. An additional problem is that providers for HIV positive patients may be limited. Doctors and nurses alike have begun to report increasing psychological and emotional strain from working with AIDS patients. Fear of becoming infected causes the health care providers to question their ethical obligation to treat HIV infected patients.³¹

²⁹ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 11–12.

³⁰ Centers of Disease Control, Department of Health and Human Services, *Public Health Reports*, 103, supp. 1 (Washington, D.C.: 1988), 3.

³¹ Institute of Medicine, National Academy of Sciences, *Confronting AIDS Update 1988* (Washington, D.C.: National Academy Press, 1988), 12.

Substance Abusers

Substance abuse is a major national problem which has social, economic and health consequences. There are 6.5 million abusers of illicit drugs in this country.³² Substance abuse treatment facilities and services are insufficient to meet the need, especially for the poor. In addition they are seldom integrated with primary care and other physical health services. For example, alcoholics are frequently malnourished and need nutritional therapy and counseling but may not receive them. Primary care service programs are needed to identify substance abusers, ensure their treatment by appropriate providers, and support them with comprehensive primary care, including preventive medical and counseling services.³³

Substance abusers frequently overlap with other high risk groups. For example, drug abusers are at significantly increased risk of HIV infection, substance abuse is a major problem among the homeless and there is a growing problem of substance abuse among pregnant women. It is estimated that approximately 375,000 children were born exposed to drugs in 1988.³⁴ Many of these infants are "boarder babies," who are ready to be released by the hospital but have been abandoned by their parents. Most boarder babies are drug exposed, and their mothers are addicts.³⁵

The Homeless

Estimates of the number of homeless individuals vary. According to U.S. Health and Human Services documents, there are between 550,000 and 600,000 homeless people in the United States on any given night. An estimated 1.3 million to 2 million persons are homeless on one or more nights in the course of the year. Families, mostly women with children, make up 23% of the homeless population. Minorities are disproportionately represented, at 2 to 4 times their proportion of the general population. The homeless have complex health needs, ranging from trauma treatment to foot care, and have difficulty integrating into a health system designed for the housed. They are afflicted by numerous cultural, environmental, and economic barriers that inhibit the maintenance of

³² Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, "Abusers of Illicit Drugs," an Attachment to a July 6, 1989 Memorandum from Jerry Britten entitled "Paper for July 12, 1989 Meeting on Access to Health Care" (Typewritten).

³³ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 13.

³⁴ Laura Feig, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, "Drug Exposed Infants and Children: Service Needs and Policy Questions," (Washington, D.C.: January 29, 1990), 2.

³⁵ Feig, "Drug Exposed Infants," 6.

good health. They are typically uneducated and/or virtually dysfunctional, limiting employment possibilities. They have no insurance or very limited insurance. One-third of the homeless suffer from severe mental illness. Living conditions are hazardous, at best, and expose the homeless to additional risks of disease. Malnutrition rates are high, and immunization rates among children in homeless families are low. The result is that group shelters for the homeless pose significant public health hazards, as they are reservoirs for communicable disease (e.g., respiratory infections, TB, chicken pox). Finally, a high percentage of the homeless belong to other high-risk population groups—that is, they have AIDS, and/or alcohol and drug dependencies. Thirty-five to forty percent of the homeless have alcohol problems and between 10 and 20 percent abuse other drugs.³⁶

Elderly

The number of older Americans is growing. Only 4 percent of the population in 1900 was elderly, whereas by the year 2000, 13 percent of the population will be age 65 or older.^{37, 38} The elderly require multiple health and social services. First, their health care problems can be both physical and mental. In addition to multiple chronic physical problems which are cumulative with age, a substantial portion of the elderly (18 percent) have significant psychiatric symptoms of acute or chronic mental illness, retardation or depression.³⁹ Many elderly, particularly the 5.7 million poor elderly, also require social/support services to address problems such as isolation and inadequate transportation to reach providers.⁴⁰

CURRENT EFFORTS—EXISTING COMPREHENSIVE PRIMARY CARE PROGRAMS

There are several types of subsidized service delivery programs that serve the estimated 26 million persons lacking a regular private sector primary care physician.⁴¹ These include hospital outpatient depart-

ments, State and local health departments, school-based programs, and Federally funded and privately supported health centers. These programs, financed through a variety of mechanisms, are designed to effectively address the barriers already described. They do so by (1) ensuring the presence of providers and facilities, (2) offering comprehensive primary medical care, (3) providing outreach and case management, and (4) including community input.

In 1987, for those Americans with family incomes of less than \$10,000, 43.8 percent of their physician contacts were in a doctor's office, 19.2 percent were with a hospital outpatient department, and 20.3 percent were with clinics. This contrasts with those families with incomes greater than \$35,000, in which 62.3 percent of physician contacts were in a doctor's office, while only 11.2 percent were in a hospital outpatient department, and 11.1 percent were in clinics.⁴² For those with Medicaid, the likelihood of receiving services from a private physician is higher. However, Medicaid recipients depend heavily on subsidized primary care programs as well since there is a shortage in many areas of primary care providers who treat Medicaid patients. For example, in Philadelphia, 23.5 percent of Medicaid recipients cite a hospital as their usual source of care.⁴³

Programs of the Federal Bureau of Health Care Delivery and Assistance

The Bureau of Health Care Delivery and Assistance (BHCDA), within the Health Resources and Services Administration of the U.S. Public Health Service, is responsible for a group of community-based programs providing primary care and case management to approximately six million poor and underserved persons through grants and manpower recruitment. The BHCDA programs, which together encompass 610 grantees at more than 1,500 sites, include 550 community and migrant health center (C/MHC) grantees comprising the basic delivery system; services to special populations (women of child bearing age and their infants, the homeless, substance abusers and persons with AIDS); and National Health Service Corps activities (recruitment, loan repayment and scholarships, and placement).

Community and Migrant Health Centers—In 1989 C/MHCs served 5.5 million Americans and had total

³⁶ Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, "The Homeless," an Attachment to a July 6, 1989 Memorandum from Jerry Britten entitled "Paper for July 12, 1989 Meeting on Access to Health Care" (Typewritten).

³⁷ Office of Disease Prevention and Health Promotion, *The Facts*, 181.

³⁸ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 13.

³⁹ National Institute on Aging, *Personnel for the Health Needs of the Elderly Through the Year 2020* (Report to Congress, 1987).

⁴⁰ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 13.

⁴¹ Aiken, Lewis, Craig, Mendenhall, Blendon, and Rogers, "The Contribution of Specialists," 1363-1370.

⁴² National Center for Health Statistics, Department of Health and Human Services, *Health, United States, 1988* (Washington, D.C.: Government Printing Office, March 1989), 106.

⁴³ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 10.

revenues of \$1.12 billion, of which 45 percent came from Federal grants. The remainder came from patient payments on a sliding fee scale and insurance collections (42 percent) and State, local and other support (13 percent).

The Comprehensive Perinatal Care Initiative—This program provided \$20 million in each of FYs 1988 and 1989 to over 200 C/MHCs for the purpose of enhancing outreach and case management activities during pregnancy and the first year of life. These services have reached approximately 100,000 mother/infant pairs.

The Health Care for the Homeless Program—Through this program \$60 million in FY 1988 and 1989 was awarded to 109 community-based organizations who offered primary care services to homeless populations. Roughly 231,000 homeless people were served in 1988, the first year of operation, with approximately 400,000 persons being served in 1989.

Substance Abuse—In FY 1988 BHCDA awarded \$3.8 million to 43 projects to combine primary care with special services for substance abusers. In FY 1989 \$9 million was provided in a collaborative effort with the National Institute of Drug Abuse to 21 community-based organizations, to integrate primary care services with substance abuse treatment. Under this program approximately 21,000 persons were seen for both substance abuse and primary care services.

AIDS—In FY 1989, under an inter-agency agreement between the Centers for Disease Control and BHCDA, three CHCs were funded to participate in an AIDS prevention and treatment program. In FY 1990 more than \$10 million will be available to expand the AIDS treatment and prevention program to as many as 20 centers located in high risk communities.

The National Health Service Corps—NHSC helps recruit and retain physicians and other health professionals in areas with shortages of these providers. It previously relied on a scholarship program which obligated recipients to serve in a shortage area. The scholarships were dramatically reduced, beginning in 1981. The NHSC now operates a small scholarship program, a program to recruit providers who serve in return for payment of their educational loans, and demonstration grants to develop state loan repayment programs. It also aids C/MHCs and freestanding sites in retaining existing providers and recruiting privately. FY 1989 funding for the NHSC was approximately \$49 million. There were approximately 2,400 physicians providing primary care, mostly although

not exclusively in C/MHCs. Forty-two new scholarships were awarded in FY 1989.

Federal Block Grant Programs

There are two Federal Block Grant programs that help support primary care services to underserved populations—the Maternal and Child Health Services (MCH) Block Grant, and the Preventive Health and Health Services (PHHS) Block Grant. Under these Block Grant programs, Federal dollars are channeled to State Health Departments, with approximately 25 to 30 percent being allocated by the States to local health departments. In FY 1989 \$465.3 million was allotted under the MCH Block Grant and \$84.3 million was awarded under the PHHS Block Grant.^{44, 45} Ways in which State and local health departments use these monies to address barriers to accessible care are described later in this paper.

Programs of the Indian Health Service

The Indian Health Service (IHS) is the principal Federal health resource for the one million American Indians and Alaska natives living on or near Federal reservations or in traditional Indian Territory. The IHS provides primary care services through the operation of 66 health centers, 5 school health centers, and approximately 100 smaller health stations and satellite clinics. Additional clinics are managed by tribes through contracts with the IHS. They operate 73 health centers, 2 school health centers, and approximately 250 smaller health stations and satellite clinics. The IHS also contracts with Indian Health Organizations in 33 urban reservations with an estimated Indian population of 380,000. These projects provide services ranging from outreach and referral to direct provision of primary care. In FY 1988, over 1 million people received primary care services through these combined programs of the Indian Health Service.⁴⁶

State and Local Health Departments

Each State has an established Health Department vested with the primary responsibility for public health. There are nearly 3,000 local health depart-

⁴⁴ Budget Appropriations Act, 1989.

⁴⁵ Conference Report on the Department of Labor, Health and Human Services, Education, and Related Agencies, Appropriated Bill 1990, (101-354). Centers for Disease Control, Preventive Health Services Block Grant (Washington, D.C.), 27.

⁴⁶ Indian Health Service, Public Health Service, Department of Health and Human Services, "Justifications of Budget Estimates to OMB" (Vol. III), 1, 56, 73.

ments providing direct community health services. In States with no local health departments the State Health Department is usually the primary provider of these community services.

States use their own resources plus Federal monies from the MCH and Preventive Services Block Grants to provide a variety of health services. In order to receive their MCH block grant allocation, States are required to match each \$4 of Federal funds received with \$3 of their own funds.⁴⁷ There is no matching requirement for the PHHS Block grant.

Many State and local health department efforts have in the past and continue to be characterized by traditional public health activities—discrete single health services (e.g., immunizations), usually provided in clinics or dispensaries. Increasingly, though, health departments are broadening their mission to provide comprehensive primary care services. The National Association of County Health Organizations estimates that approximately 25 percent of local health departments provide organized primary care services. The Association is working to get estimates of the number of persons served by these programs.

The Private Sector

Philanthropic foundations and others have pioneered new approaches to building capacity and reaching high risk groups. Also, there are currently over 500 private, non-Federally funded health centers throughout the country that provide comprehensive primary care services.⁴⁸ However, support for ongoing care of the indigent is increasingly unstable, and the cross-subsidies of the poor by the well-off are rapidly becoming a thing of the past. Data could not be obtained on the number of individuals who receive primary care services through private clinics and other philanthropic programs.

Public and Non-Profit Community Hospitals

Hospitals are by necessity the only family doctor in many urban and rural areas. Oftentimes, because private physicians are unavailable in their areas, inner city dwellers (particularly the poor and minorities) rely on hospital emergency rooms or outpatient departments as their principal source of primary care.

As noted earlier, the poor are more likely than the nonpoor to see physicians in a hospital outpatient department or emergency room (19 percent of the poor vs. 11.2 percent of the non-poor).⁴⁹ Also, the uninsured are more likely than any other group to use hospitals for primary care. The American Hospital Association (AHA) estimates that approximately 4.9 million uninsured persons rely on hospitals for such care.⁵⁰ In 1987, 4,242 hospitals, or 68 percent of the 6,281 hospitals responding to the AHA survey, provided non-emergent primary care services through an organized outpatient department.⁵¹

The hospitals that serve many of these patients are facing severe financial strains, jeopardizing their capacity to provide care. Services in hospital clinics are frequently episodic and disease oriented, with little continuity or coordination among the various specialty clinics, let alone with outside agencies.⁵² This makes care costly and reduces effectiveness. Additional reasons that primary care delivered in hospital outpatient departments is more expensive than care delivered in a free-standing setting include: (1) lack of control by outpatient department directors over their own costs; (2) the degree to which the availability of sophisticated and expensive technology within the hospital setting encourages its utilization; and (3) the fact that "sicker" patients tend to be seen in outpatient departments.⁵³

Responding to these growing financial strains, as well as to the increasing numbers of people who are relying on hospitals for primary care, an unknown number of both public and not-for-profit hospitals have reorganized their outpatient departments and neighborhood clinics in recent years to provide comprehensive primary care, as opposed to episodic care, in a variety of specialty clinics or emergency rooms.

School Based Programs

The Center for Population Options reports that there are 150 school-based health centers operating in middle or junior high schools and senior high schools in most cities as well as in many rural areas. The number is somewhat higher if centers located adjacent to school property are included. This group is work-

⁴⁹ National Center for Health Statistics, *Health, United States, 1988*, 106.

⁴⁷ Edward R. Klebe, Congressional Research Service, The Library of Congress, "Health Services Programs for Populations in Need," (August 17, 1989), 2.

⁴⁸ National Association of Community Health Centers (unpublished data, Washington, D.C.: October 27, 1989).

⁵⁰ Irene Frazer, American Hospital Association, Data submitted by memorandum to Department of Health and Human Services (Chicago, Ill.: March 23, 1990).

⁵¹ Frazer, memorandum.

⁵² Diana B. Dutton, Ph.D., "Children's Health Care: The Myth of Equal Access," in *Better Health for Our Children, The Report of the Select Panel for the Promotion of Child Health*, Vol. IV (1981), 382.

⁵³ Marsha Gold, "Hospital-Based versus Free-Standing Primary Care Cost," *The Journal of Ambulatory Management*, 2 (1) (February 1979).

ing to get estimates of the number of young persons served. Clinics are located in 32 states and 91 communities. The number of clinics have increased five-fold since 1983. These clinics serve low-income, predominantly minority youth who have limited access to other sources of health care. One-third of all school based clinic users have no health insurance. For about a half of all enrolled students, school-based health clinics are their sole or primary source of health care. A wide range of medical and counseling services are provided, including primary health care and preventive services.⁵⁴

School based health centers are funded by a variety of public and private sources. In 1989 approximately two-thirds of the funding came from public sources, including States, cities, counties, Block Grants, Medicaid, the EPSDT program, and school districts. A number of school based health programs are part of a Federally funded health center. Foundations are virtually the only source of private funding for school-based health clinics. In 1989, foundations provided 31 percent of total funding, down from 41 percent the previous year. Insurance payments and patient fees each year accounted for less than one percent of clinic funding.⁵⁵

THE EFFECTIVENESS AND IMPACT OF EXISTING PROGRAMS

There is strong evidence that the existing comprehensive primary care programs described above have made significant inroads in reducing barriers to the receipt of appropriate health care. More evidence exists about federally funded primary care centers than about other programs. However, if characteristics of the other programs are similar, it should be possible to assume that they would share the attributes of federally funded centers.⁵⁶ The evidence described below is presented both in terms of specific ways in which each barrier is being reduced, and improvements in health status/outcome measures.

Reducing Financial Barriers

Subsidized primary care service delivery programs play a significant role in serving the nation's poor.

⁵⁴ Claire Brindis, Dr. P.H., "A Synthesis of Recent Evaluation Findings On School-Based Health Centers," presented as part of a National Health Policy Forum Workshop (Washington D.C.: November 28, 1989), 1-2.

⁵⁵ Brindis, "School-Based Health Centers," 2.

⁵⁶ Bonnie Lefkowitz and Dennis Andrulis, "The Organization of Primary Health and Health Related Preventive, Psychosocial, and Support Services for Children and Pregnant Women," in *Better Health for Our Children, The Report of the Select Panel for the Promotion of Child Health*, Vol. IV (1981), 456.

Approximately 60 percent of those served by Federally funded C/MHCs have incomes under the poverty level, and another 25 percent are between 100 and 200 percent of poverty.⁵⁷ Similarly, 50 percent of those served through hospital outpatient and health departments are poor.⁵⁸ These programs, by targeting to underserved groups, care for the uninsured and make Medicaid a reality for many people who, although Medicaid-eligible, lack access to a provider.

Reducing Capacity/Resource Barriers

C/MHCs are required to be in the underserved urban and rural areas in the United States with the most substantial shortfalls of primary care providers. In addition, evidence suggests that both urban and rural centers have increased the utilization of health services.^{59, 60, 61} Similarly, hospital outpatient departments and local health departments lower access barriers by their locations in underserved areas.

The NHSC scholarship and loan repayment programs attract physicians to underserved communities. Priority of selection of scholarship and loan repayment recipients goes to individuals with backgrounds and interests compatible to practice in underserved areas, and to individuals enrolled in institutions that have a history of producing large numbers of primary care physicians and who have an emphasis on care to underserved populations. C/MHCs affiliate with hospital residency programs, especially in family medicine and other primary care specialties, in order to receive direct services from residents, recruit them as future staff members, and improve the retention of C/MHC physicians who value the hospital affiliation and its teaching opportunities. Notable examples are found in Seattle, Washington and Bronx, New York.

Federal primary care programs also help build systems of care in underserved areas by collaborating with State and local health departments through State Cooperative Agreements and Primary Care Associations and local coalitions. The goal of these collaborative efforts is to ensure the availability of primary

⁵⁷ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 16.

⁵⁸ M.G. Kovar, "Background Paper for the Select Panel for the Promotion of Child Health," (unpublished data from the National Health Interview Survey for 1974, Washington, D.C.: 1980).

⁵⁹ R.A. Reynolds, "Improving Access to Health Care Among the Poor—The Neighborhood Health Center Experience," *Milbank Memorial Fund Quarterly: Health and Society* 54 (Winter 1976): 47-82.

⁶⁰ H. Snyder, et al., "The Effect of Provision of Medical Facilities on Use by the Migrant Workers in California," *Medical Care* 6 (September-October, 1968): 394-400.

⁶¹ G. Sparer and L.M. Okada, "Chronic Conditions and Physician Use Patterns in Ten Urban Poverty Areas," *Medical Care* 12 (July 1974): 549-560.

care services and case management, while avoiding duplication.

Reducing Organizational/Operational Barriers

A number of service delivery programs, in conjunction with State and local health departments, are working to coordinate services and resources available from multiple and varied programs, thus enhancing the accessibility of service delivery. This includes case management of the medical continuum, as well as of a broad range of welfare and other support services. The Office of Maternal and Child Health is currently funding demonstration projects to implement one-stop shopping programs at C/MHCs and other sites. This involves co-location of health, social, and welfare services from different agencies in the same physical location. C/MHCs have historically jointly addressed the social and clinical aspects of health care. Currently, 113 C/MHCs receive WIC funding, and many more provide WIC services directly or by arrangement. Three to four demonstration projects of new one-stop shopping approaches are planned for FY 1990. Finally, 35 State and Regional Primary Care Associations and 33 State Primary Care Cooperative Agreements are working with their respective States on presumptive and on-site Medicaid eligibility. C/MHCs in at least 20 States are eligibility determination sites.

These efforts to coordinate various programs help to avoid duplication, and increase the likelihood that individuals will access all that is available to them. Such integration is critical to a disadvantaged population faced with a patchwork of programs at different sites and with oftentimes inconsistent requirements.

Reducing Cultural/Social Barriers

Subsidized service delivery programs have effectively focused their efforts on minority groups. Approximately 64 percent of those served by CHCs are members of minority groups, and those served by MHCs are 50 percent Hispanic and 35 percent black.^{62, 63} Similarly, over 50 percent of those served by hospital outpatient and health departments are minorities.⁶⁴ Finally, there is considerable support for

education of minority health professionals, since these professionals often serve minority, underserved populations. The NHSC recruitment program has developed a recruitment plan to increase the number of Hispanic officers by 150 within 2 years. Additionally, the National Medical Association, under a contract with the Health Services and Resources Administration, actively promotes education for minority health professionals by visiting and providing informational materials to minority students in colleges.

In addition to the delivery of medical care, primary care programs can offer a wide range of outreach services which facilitate the receipt of care which is available. C/MHCs are governed by consumer-based Boards of Directors. These volunteers, who represent a broad spectrum of community concerns, encourage outreach activities which will help to ensure culturally sensitive and appropriate care. Examples of innovative approaches of C/MHCs to outreach are a "mom-mobile" for Indianapolis centers and use of athlete celebrities to reach school aged youth in Detroit.

The effectiveness of culturally sensitive outreach services is illustrated by a 1974 study which compared pregnant women who used health centers with outreach services, traditional hospital outpatient departments, and Medicaid physicians, and found that the women who used health centers were most likely to be satisfied with their obstetric and pediatric care and most likely to make postnatal visits.⁶⁵ More recently, several CHCs in Pennsylvania which sponsor lay home visiting programs have shown that since implementation of home visiting services, the rates of prenatal visit compliance, the return rate for postpartum care, returns for routine pediatric care, attendance at prenatal and parenting classes, compliance with family planning appointments and WIC registration have all improved.⁶⁶

In addition to outreach activities, primary care programs can provide a wide range of social services which address language, educational, environmental, and other cultural barriers. An example is the "Women's Residential Program," offered by the Economic Opportunity Family Health Center in Miami, Florida. This program, which was developed to respond to the problem of substance abuse among women of child-bearing age, provides detoxification and preventive health services (i.e., individual and group therapy) as well as GED preparation, job training and placement, parenting education and coun-

⁶² The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 16.

⁶³ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 16.

⁶⁴ Kovar, "Background Paper for the Select Panel for the Promotion of Child Health."

⁶⁵ J. Birch, and S. Wolfe, "New and Traditional Sources of Care Evaluated by Recently Pregnant Women," *Public Health Reports* 91 (September-October, 1976): 412-422.

⁶⁶ Marcella E. Lingham, Ed.D., Letter to Natalie Levkovich, Quality Community Health Care, Inc. (Philadelphia, Pa.: November 13, 1989).

seling, long-term follow-up, and child care on the premises. As another example, Beaufort-Jasper Comprehensive Health Services, in South Carolina, provides a broad range of medical as well as social support services in a community with a very high infant mortality rate, and predominantly poor residents. A high proportion of the population lives in substandard housing. In addition to health care, the center provides environmental services. One very tangible result, which has an obvious impact on health status, is the fact that the center has installed or updated well over 100 water systems for families who previously had poor water systems supplies.⁶⁷

Clinical Outcomes/Health Status

A number of studies have shown that, in their impact on the underserved families they were intended to serve, primary care programs have been quite successful. Many of these studies included control groups who used Medicaid but not a service delivery program. Unfortunately, most of the research noted below was conducted in the 1970s and early 1980s. There has been little analysis on the effectiveness of primary care models in the last ten years.

Efficiency and Cost-Effectiveness—CHC patients have lower hospital admission rates, shorter lengths of stay, and make less inappropriate use of emergency rooms than similar patients not using CHCs.^{68, 69} For example, an extensive study in five cities found hospital days were reduced by 25 percent for child and adult users of CHCs compared with all similar nonusers in control groups and 22 percent for users compared with those in control groups using a private physician.⁷⁰ Similar results have been found by others. The effect of primary care service delivery programs was demonstrated in a three-city study which found that Medicaid recipients who were users of community health centers had total annual Medicaid costs of 6–58 percent less than a control group of Medicaid recipients who relied on hospitals and private physicians for their usual source of care.⁷¹ Additionally, emergency room visits by children were reduced 38 percent by primary care centers in

Rochester.⁷² Where hospital outpatient departments resemble comprehensive primary care centers in services and organization, similar findings have been noted. For example, one study shows that users of a hospital-based health center in Boston had significantly lower use of emergency rooms than nonusers.⁷³

Infant Mortality—Health centers have a beneficial and statistically significant effect on both white and black infant mortality rates. In a nationwide analysis, counties served by health centers have been found to have white infant mortality rates that are 1.5/1,000 lower, and black infant mortality rates that were 2.9/1,000 lower, than those in surrounding counties. Counties with four or more health centers were found to have infant mortality rates as much as 10 percent lower than counties with no health centers.⁷⁴

The provision of comprehensive primary care services by health departments has also been associated with improvements in the area of low birth weight and infant mortality.⁷⁵ For example, between 1970 and 1978, the Cincinnati Health Department reduced infant mortality by eight percent. Also, during provision of primary care services between 1970 and 1977, Maricopa County (Arizona) had its low birth weight rate reduced by 16 percent, and Pickens County (South Carolina) had its nonwhite infant mortality rate reduced by 38 percent, from 40.7 to 25.3, between 1970 and 1973. Finally, Denver's Neighborhood Health Program (a joint CHC/health department effort) resulted in a 25-percent reduction in infant mortality.⁷⁶

Childhood Diseases—Primary care programs have reduced rheumatic fever and untreated middle ear infections, and have brought about an increase in the number of immunized children. For example, one study attributes a 60 percent decrease in rheumatic fever in Baltimore areas served by primary care centers to early detection and treatment of streptococcal infections.^{77, 78}

⁷² L.E. Hochheiser, "Effect of the Neighborhood Health Center on the Use of Pediatric Emergency Departments in Rochester, New York," *New England Journal of Medicine* 285 (1971): 148–152.

⁷³ E.J. Sussman, "Can Primary Care Deliver?" *Journal of Ambulatory Care Management* 2 (August 1979): 23–29.

⁷⁴ Michael Grossman, Ph.D., and Fred Goldman, Ph.D., "An Economic Analysis of Community Health Centers," National Bureau of Economic Research (January 1983).

⁷⁵ Lefkowitz and Andrulis, "The Organization of Primary Health Services," *Better Health for Our Children*, 460.

⁷⁶ A. Chabot, "Improved Infant Mortality Rates in a Population Served by a Comprehensive Neighborhood Health Program," *Pediatrics* 47 (June 1971): 989–994.

⁷⁷ Schorr, *Within Our Reach*, 132.

⁷⁸ L. Gordis, "Effectiveness of Comprehensive Care Programs in Preventing Rheumatic Fever," *New England Journal of Medicine* 290(8) (August 16, 1973): 330–336.

⁶⁷ Lefkowitz and Andrulis, "The Organization of Primary Health Services," *Better Health for Our Children*, 475.

⁶⁸ Schorr, *Within Our Reach*, 132.

⁶⁹ Andrea McCrensky-Kremer and Richard Kremer, "Overview of DRGs: What they are and How They Work," (draft unpublished report, Harrisburg, Pa.: September 27, 1989), 13–15.

⁷⁰ L.M. Okada and T. Wan, "Patterns of Health Services Utilization in Urban Low Income Areas." Paper presented to the Institute of Management Science/Operations Research Society of America, Joint National Meeting, New Orleans, La.: April 30–May 2, 1979.

⁷¹ The Bureau of Health Care Delivery and Assistance, "The Bureau's Unique Role," 21.

Clinical Management—Studies of clinical management and quality of care, measured by recordkeeping, indicate that Federal primary care programs are at least equal and sometimes superior to other established providers, including private physicians, and that health department primary care programs are superior to private physicians and outpatient departments.^{79, 80, 81} Many Federal primary care centers pioneered the team approach as well and have found it effective.^{82, 83, 84}

Social Services—Social support services offered through primary care programs are critical in protecting an individual's health. For example, programs to counteract certain environmental hazards through organized health settings have been effective in reducing morbidity and mortality.^{85, 86}

FUTURE DIRECTIONS

Although the successes to date are encouraging, more remains to be done. A range of activities is needed to reduce barriers to care, and ultimately improve health status. These activities, for the most part, are not new. They are currently being implemented at innovative organized primary care delivery sites. However, implementation is far from universal. A model for reform, which describes an optimal continuum of activities, is described below. Additionally, the interaction between financing and delivery system reform is discussed. Finally, strategies for continued targeted direct support of organized primary care delivery programs are presented.

⁷⁹ M.A. Morehead, R.S. Donaldson, and M.R. Servalli, "Comparisons Between OEO Neighborhood Health Centers and Other Health Care Providers of Ratings of the Quality of Health Care," *American Journal of Public Health* 61(7) (July 1971): 1294-1306.

⁸⁰ M.A. Morehead and R.S. Donaldson, "Quality of Clinical Management of Disease in Comprehensive Neighborhood Health Centers," *Medical Care* 12 (1974), 301-315.

⁸¹ M.A. Morehead, *Final Report 1968-1976 of Review of Federally Supported Neighborhood Health Centers*, Contract Number 105-74-170 (Albert Einstein College of Medicine, Bronx, N.Y.: 1977).

⁸² Morehead, "Review of Federally Supported Neighborhood Health Centers."

⁸³ M.H. Becker, R.H. Drachman, and J.P. Kirscht, "A Field Experiment to Evaluate Various Outcomes of Continuity of Medical Care," *American Journal of Public Health*, 64 (November 1974): 1062-1070.

⁸⁴ K. Davis and R. Marshall, "Personal Health Care Services for Medically Underserved Populations," *Papers on the National Health Planning Guidelines*, Health Resources and Services Administration, Department of Health and Human Services (Washington, D.C.: 1977).

⁸⁵ C. Spiegel and F. Lindaman, "Children Can't Fly: A Program to Prevent Pregnant Childhood Morbidity and Mortality From Window Falls," *American Journal of Public Health* 67 (1977): 1143-1146.

⁸⁶ P. Peacock, A. Gelman, and T. Lutins, "Preventive Health Care Strategies for Health Maintenance Organization," *Preventive Medicine* 4 (1975): 183-225.

Model for Addressing Barriers

For optimum effectiveness, a model service delivery program would include the components described below.

Medical Primary Care—Comprehensive medical primary care should be offered in an environment that is physically accessible to the population it is intended to serve, and that has a sufficient number of appropriately trained professionals who are sensitive to cultural, ethnic, and language differences.

For many services, the manner of delivery is as important as the fact of delivery. For this reason, in addition to increasing the numbers of health care providers, organized primary care programs should increase efforts to recruit and/or train professionals that are perceived by those they serve as people who care about them and respect them. Schorr states in *Within Our Reach* that "staff must be able to respond to the individual needs of those they serve. The nature of their services, the terms on which they are offered, the relationships with families, the essence of the programs themselves—all take their shape from the needs of those they serve, rather than from the precepts, demands, and boundaries set by professionalism and bureaucracies."⁸⁷

Case Management and Coordination of Services—Case management activities should include proper and timely referrals to medical specialists, as well as to programs for mental health and substance abuse services. Additionally, there should be case management, and where possible, co-location of a broad range of welfare and other support services, including income support, housing, and job training. Successful programs are those that provide services that are coherent and easy to use. Relying too heavily on referrals to other agencies interferes with getting needed services.⁸⁸ Thus efforts to integrate services should in particular encourage co-location of related services and development of common eligibility requirements, rather than simply an active referral network. The importance of integrating a wide range of available services has been noted by David Rogers, former President of the Robert Wood Johnson Foundation. He states that service programs cannot respond to intertwined and interconnected needs without regularly "crossing traditional professional and bureaucratic boundaries."⁸⁹ Other support services are necessary to encourage at risk populations to maintain participation in care, and arrange for additional care

⁸⁷ Schorr, *Within Our Reach*, 259, 269, 278.

⁸⁸ Schorr, *Within Our Reach*, 258.

⁸⁹ Schorr, *Within Our Reach*, 257.

as needed. Examples of such services which organized primary care programs should work to enhance include on-site day care, health education programs, bilingual services, and environmental services.

Community Outreach—In order for needy populations to best benefit from the facilities, services, and coordinating systems which may be in place, it is critical that there be a strong outreach program which fosters health prevention and promotion behavior, encourages early entry into the health and social services systems, and includes rigorous and continuous follow-up activities. These outreach activities are more effective if they are linked to a service delivery program, rather than existing independently. The solution lies in helping communities implement their own change in health behaviors, so that available services and resources will be used more often, and more effectively. Ways for primary care service delivery programs to increase their outreach efforts include use of volunteer outreach workers, public information campaigns directed at high-risk groups, telephone hotline services, transportation and home visiting programs, and periodic review of office or clinic procedures to make certain that access is easy and prompt, bureaucratic requirements minimal, and the atmosphere welcoming.⁹⁰

Community Input and Responsiveness—Primary care programs should address unique local circumstances and health care problems, and should be flexible enough to meet the diverse needs of the underserved.

Evaluation—There has been a recent dearth of studies on the effectiveness of primary care models and services. Part of any model should be the capability to study reforms and provide short term feedback and longer term evaluation of impact.

The Interaction Between Financing and Delivery System Reform

Expanding health care insurance coverage should reinforce—not replace—support for primary care delivery systems. Specifically, insurers should not be allowed to discriminate against subsidized organized settings such as CHCs. Currently, organized programs may not be recognized as providers by insurers or HMOs, and if they are recognized they may be paid only for physician services rather than via an institutional rate. Depending on their design, financing reforms can increase the capacity of direct delivery

providers. If insurance covers patients previously uninsured or underinsured, delivery systems can then use their State, Federal or private funds to develop additional facilities, to expand types of services and the number of patients served at existing facilities, and to provide additional outreach and case management services. These support and facilitating services are often not appropriate for reimbursement through a general insurance program because they are difficult for insurers to validate and control.

Recent Federal financing legislation has been moving in directions which will increase Medicaid reimbursement to community based programs, and therefore enhance their ability to use other funds to reduce barriers to care. Specifically, the Medicaid program has been revised several times to expand eligibility to mothers and young children. Also, under the Reconciliation Act just passed by the Congress, effective April, 1990, all Federally funded C/MHCs as well as other primary care centers that meet similar qualifications will be reimbursed by Medicaid at 100 percent of reasonable costs. Additionally, effective April 1990, centers in all States are recognized as a provider for purposes of Medicaid reimbursement. Unlike the previous rules, in which CHCs in certain States have been paid based on individual physician fees and/or rates considerably less than cost, the new legislation acknowledges and pays for the increased expenses associated with providing comprehensive, case-coordinated primary care.

Table 1 illustrates the relationship between Federally funded C/MHCs and financing reforms. With significant increases in insurance coverage, for the same amount of grant funds, the number of persons served could be increased from 6.2 to 8.4 million and the range of services increased to provide outreach, prevention and support services for all users. This assumes that (1) insurance will cover clinical services and case management for all persons served, (2) grant or other funds will be used for special outreach, health promotion/disease prevention, support and facilitating services, and (3) the total number of users is determined by the availability of grant and other funds.

Delivery Reform

Financing reforms are necessary but not sufficient in improving access to health care. Even if comprehensive health care were financed completely for everyone, non-financial barriers would still prevent many people from receiving effective, timely, care. The inadequacy of financing reforms alone was noted

⁹⁰ Sarah S. Brown, Ed., *Prenatal Care: Reaching Mothers, Reaching Infants—Summary and Recommendations* (Washington, D.C.: Institute of Medicine, National Academy Press, 1988), 14.

by the National Governors Association (NGA) following the recent implementation by many States of Medicaid expansions for pregnant women and their infants. Specifically, the NGA found that some communities in isolated rural or high risk inner city areas lacked health care providers and facilities. Even where there were providers, many physicians in the private sector were unwilling or unable to take on additional patients, and continuity of care was frequently lacking. They were not prepared to offer the broad spectrum of preventive, support and facilitating services needed by a disadvantaged population.⁹¹ Gail Wilensky has similarly noted that insurance schemes alone are insufficient. She has stated that "For some populations—those who are difficult to reach or have special needs . . . specially targeted programs directed to providers who are trained and equipped to deal with these special populations are likely to be more efficient and effective than generalized insurance programs."⁹²

Table 1 How Increased Reimbursement Affects Capacity and Services in C/MHCs

| | Current Policy (1988) | Full Implementation of Reforms Enacted in 1989 | Full Insurance Coverage of All Persons and All Clinical Services |
|----------------------------------|--------------------------|---|---|
| Federal Grant..... | \$440m..... | \$480m..... | \$480m |
| Patient/Third Party Payments. | 417 | 457 | 1,192 |
| Other Funds..... | 158 | 158 | 158 |
| Total Revenues... | 1,015..... | 1,095..... | 1,830 |
| Persons Served | 5.7 million... | 6.2 million... | 8.4 million |
| Cost/person..... | \$178..... | \$178..... | \$218 |

1. Figures are not adjusted for inflation
2. Clinical services represent 80% of total costs currently in columns 1 and 2; 65% in column 3. In column 1 the total cost per person is \$178, of which clinical costs are 80% of that, or \$142. \$142 is 65% of \$218, the cost/person in column 3. This increase in cost/person from \$178 to \$218 reflects increased outreach and support services.
3. Federal grant funds in columns 2 and 3 based on FY 1990 appropriation less program support and lag in outlays for calendar year.

Direct support of organized primary care programs is required to meet the special needs of certain population groups whose needs cannot be met solely through the provision of private or public health insurance. Strategies for this support are described below.

Facilities—Support for organized primary care delivery systems should be maintained at a level which, in conjunction with financing reforms, allows an increase in the number of sites, as well as increases in

the capacity of existing sites to serve additional persons. This could be linked to the concept of ensuring that underserved populations have a provider of last resort (i.e., local health department, freestanding clinic, reformed hospital outpatient department, or C/MHC).

Personnel—Manpower development should be aimed at attracting and retaining health professionals in minority and other underserved areas. Strategies might include: (1) continued support of existing programs such as the National Health Service Corps and minority health education programs; (2) promotion of the appropriate use of mid-level health professionals, through the development of model state practice acts; (3) examining proposals to address problems regarding professional liability and (4) development of professional support networks (e.g., telecommunications networks with other providers to provide adequate backup and support services).

Outreach and Support Services—There should be targeted support for the development and delivery of innovative outreach and other social and support services which will facilitate access to and continued participation in health care. Strategies might include, but not be limited to: (1) demonstration grants to enlist volunteers from the community, along with the training and management necessary to ensure appropriate use and retention of volunteers; (2) encouraging communities to provide free or reduced-cost transportation for pregnant women and other high risk, underserved groups; and (3) working with States and localities to promote availability of home visits by public health nurses in underserved areas.

Coordination—Coordination could be improved through increased Federal financial, administrative and technical assistance support for coordination and co-location of services for underserved groups, particularly vulnerable special population subgroups such as the homeless, pregnant women, and substance abusers. This includes support for (1) establishing one-stop shopping programs within C/MHCs and local health departments, and (2) simplifying and standardizing eligibility requirements and procedures for public programs.

Evaluation and Research—In order to ensure effective and efficient use of resources, the Federal Government should promote the development of systems to assess continuing gaps in access to care, help plan for a provider of last resort in every high need underserved area, and evaluate existing programs for their cost effectiveness and impact on health status.

⁹¹ Ian T. Hill, "Broadening Medicaid Coverage for Pregnant Women and Children," *State Policy Responses* (Washington, D.C.: National Governors Association, 1988).
⁹² Gail Wilensky, "Filling the Gaps in Health Insurance," *Health Affairs* 7 (Summer 1988): 141.

LIMITING FAVORED TAX TREATMENT FOR EMPLOYEE HEALTH INSURANCE

Marilyn Moon, Ph.D.*

Proposals to expand health care coverage to the uninsured often suggest as a source of revenue a reduction in the tax preferences given to those who have employer-paid coverage. Current tax law allows employers to deduct their contributions to health insurance for employees as a cost of doing business, and employees are not required to declare this benefit as taxable income. Consequently, such benefits are not taken into account for either personal income or payroll (Social Security) taxes. The total revenue loss for both the employer and employee exclusions is projected to be about \$35 billion in 1989.

All or a part of the health insurance premium paid by the employer could be treated as income and subjected to the personal income tax. The most popular proposal for taxation of health insurance is the "tax cap" approach. This approach would, for example, allow the continued exclusion from income of a portion of the health insurance premium, say \$250 per month for family coverage, and tax only amounts above that level. In that way, many employees would continue to receive a tax free subsidy toward their insurance costs, while very expensive policies would be partially taxed.

Tax preferences for health insurance coverage have helped to stimulate employer participation and hence avoid the necessity for more public sector activity. In addition, because insurance represents an "in-kind" benefit, taxing it would ask individuals to pay in cash for a benefit that came in a restricted form (as insurance, not cash). The principle of not taxing such in-kind benefits has been long-standing, although options for taxing various in-kind benefits are increasingly being proposed as a means for further raising revenues. Opposition to taxing health benefits thus also arises from the precedent that would be set for taxing

other in-kind benefits such as private pension contributions.

Proponents and opponents of changing the tax status of health insurance benefits both argue about fairness—the subject of this memo. Proponents fault the disproportionate benefits that go to upper income workers who are more likely to have generous coverage—and who benefit more because of the progressive nature of the income tax—as compared to less well off workers. Opponents of a change, on the other hand, cite many of the difficulties in fairly setting appropriate tax caps. The following discussion explores both sets of arguments.

THE BASIC INEQUITIES OF THE CURRENT SYSTEM

The major inequities of the current system cited by proponents of taxing insurance benefits relate to the share of the benefits that flow to a relatively small number of high income taxpayers. High-wage workers are more likely to be covered by their employers, and when they are, the value of the benefits they receive is likely to be higher. In addition, if these benefits were to be taxed, they would be subject to higher marginal rates than the rates faced by noncovered workers. Thus, the tax benefits for each dollar's worth of insurance are larger for those with high incomes. For example, exempting \$1,000 worth of premiums saves a low income family only \$150 in potential income taxes, but the same premiums result in \$280 or \$330 in tax savings to those with higher incomes. And for a very low-wage worker who pays no federal income tax, there is no tax subsidy whatsoever.

The concept of base broadening suggests that all employer benefits ought to be subject to tax. Con-

* This report prepared by Marilyn Moon, Ph.D., Senior Research Association, the Urban Institute.

sider, for example, the case of workers who can bargain either for higher wages or more health insurance. They are explicitly trading off one for the other, so why shouldn't they pay taxes equally on both types of benefits? Bargaining units correctly recognize that insurance benefits, which are not taxed, may actually be a better deal for employees who can give up one dollar of taxable income for one dollar of insurance that is not subject to tax.

Many tax experts and health economists have recognized that the exclusion encourages individuals to seek more health insurance coverage than is desirable from the standpoint of economic efficiency. That is, because the benefits cost them little or nothing, individuals are inclined to seek more coverage than they would be willing to pay for if they had to bear the full cost. Moreover, individuals whose earnings come solely in cash (and who have no choice) effectively pay higher tax rates than other workers with nontaxed benefits in their total compensation package. Further, some would argue that the resulting lower revenues to the federal government from these tax exclusions mean a lower ability to fund public programs to meet the needs of persons who cannot afford to buy insurance, creating even further inequities. Thus, on both equity and efficiency grounds a good case can be made for taxing health insurance benefits.

EQUITY PROBLEMS IN TAXING HEALTH INSURANCE

The very fact that health insurance is an in-kind benefit creates some inherent inequities. The costs of such insurance vary widely even for similar policies, yet the recipient of insurance coverage may not consider that he or she is better off than a fellow worker just because the policy costs more. If services covered are the same, why should one individual be subject to more tax?

If employer paid insurance premiums were subjected to the federal personal income tax, persons whose health insurance premiums were expensive—even if for no reason under their own control—would pay higher taxes. And the problem remains even under the tax cap approach. The intention of a tax cap is to discourage excessive coverage, while still allowing a tax break on the basic insurance premium. But, a single cap does not allow a distinction between excessive coverage and expensive coverage. Although the goal of taxing the insurance benefits is not to create a tax that varies by health status, the results could move in that direction if the inequities are severe.

Another consequence of taxation of insurance benefits may be to discourage coverage of benefits such as preventive services. While some would argue that coverage beyond a minimum package should not be subsidized, other health analysts would argue that additional benefits ought to be encouraged. Choosing what represents excessive coverage (and hence setting a tax cap) would not be an easy task.

Variance in insurance costs stems from a number of factors, some more difficult to deal with than others. First, levels of insurance premiums differ within a given region depending upon the size of the group being offered insurance. Large employers generally face lower costs per worker since the pool of individuals covered by insurance is very large. Employers with only a few workers find insurance costs to be particularly high—a trend that is increasing over time. These represent cost differences beyond the control of the employee who will be penalized if insurance premiums are taxed or taxed above some simple cap.

Second, age and other demographic characteristics of workers in a particular employment setting may result in different insurance premiums. An employer with a large supply of older workers, for example, might face much larger insurance costs—and that could be further exacerbated if the business is a small one. All workers for that employer regardless of age would face higher than average tax liabilities for the benefits they receive. (Or, if differential premiums were to be applied, then older workers or women of child bearing ages might be singled out for heavy tax burdens.)

Basic health care costs and patterns of actual use of services also show great differences by geographic location. Thus, someone in the northeast or north central United States experiences higher premiums—and thus potentially higher taxes—than someone in similar circumstances in the west or the south. Should individuals be taxed differently because the rates that providers charge vary? If they receive the same coverage, individuals may be able to argue appropriately that they should not be held accountable for differences in hospital costs and doctors fees, for example. On the other hand, higher doctors fees tend to occur in high wage areas where workers are also likely to be paid more than, for example, their rural counterparts.

Differences in premiums resulting from varying patterns of use of services pose an even more difficult problem since more care is received by those for whom higher premiums are charged. On the other hand, patterns of use may be more attributable to doctors' decisions than to patient demand. We know, for

example, that practice patterns differ around the country—in some areas many more procedures are performed than in other areas. If so, individuals could again argue that they should not be penalized through the tax system for differences in premiums that are largely beyond their control.

Some proponents of a tax cap argue that the whole purpose of the cap is to put pressure on providers to deal with each of these potential problems. When individuals are faced with having to pay higher taxes, they will presumably demand reforms in the insurance market. This competitive approach assumes that individuals and their employers will be able to have enough purchasing power to force improvements in the market.

SOME SOLUTIONS TO THE INEQUITIES

Several options exist to reduce the inequities created by taxing insurance premiums. Differential caps could be specified depending upon region of residence. But other differences discussed above will vary by firm, so some further adjustment might be needed. For example, an index might be assigned to each individual's reported insurance amount to adjust for differences in the premiums that reflect factors other than scope of coverage. Such an index might be calculated by insurers to reflect differences in the actuarial costs to firms as compared to a national average for some standard policy. That index could then be used, for example, to lower the reported taxable value of unusually high premiums.

Employees of large firms are already likely to be relatively well protected from arbitrary variations in the cost of premiums if a firm-wide average is used to calculate the premium. That is, if the pool of em-

ployees is large enough and covers many areas of the country, average premiums are likely to wash out arbitrary differences. Similarly, small firms could be better insulated if their insurance costs were modified by creating large risk pools that would also implicitly weight all the various reasons for insurance premium differences and average them out. Such averaging would likely help small firms with high costs, but if confined to a particular region would not address the issue of geographic variation in insurance costs.

When combined with other health care proposals, a tax cap could also avoid most of the equity issues raised here. Consider, for example, the tax cap in combination with an employer mandate. If the cap is set at or above the amount needed to buy the mandated package, covered individuals would only pay tax when their insurance was more comprehensive than the standard package. And since many mandated insurance proposals would include options for small employers to have access to affordable insurance, premiums should show less variation as compared to the current insurance market. In fact, any reform that improves the private market for insurance could help. For example, if improved risk pooling enabled small firms to buy less expensive insurance, employees would not face taxes on unnecessarily high insurance premiums.

In that sense, combining tax cap financing with health care proposals that result in more reasonably priced insurance complement each other well and reduce one of the major objections to taxing a portion of employer-paid health insurance premiums. On the other hand, proposals such as expanding Medicaid coverage to more of the uninsured would do little to improve the private insurance market; financing such a proposal with a tax cap could be criticized on equity grounds unless some of the modifications described above were also made to the tax cap.

FEWER RESOURCES, GREATER BURDENS: MEDICAL CARE COVERAGE FOR LOW-INCOME ELDERLY PEOPLE

Diane Rowland, Sc.D.*

EXECUTIVE SUMMARY

This background paper, prepared for the Pepper Commission, profiles the economic and health status of the elderly population, examines the financial burden associated with obtaining health care services, and offers recommendations to improve protection. Particular emphasis is given to examining the burdens medical care expenses impose on low-income elderly people and the extent to which coverage to supplement Medicare can assist in alleviating burdens for this group.

Today, 3.5 million elderly people are poor with incomes below the Federal poverty level of roughly \$6,000 per year. Another 8.2 million are near-poor with incomes between 100 and 200 percent of the poverty level. Overall, 40 percent of the elderly population is poor or near-poor, but women, those of advanced age, and minorities are more likely to be low-income. Low-income elderly people are more likely to be in poor health and suffer from chronic conditions requiring ongoing medical care than other elderly people.

Nearly all elderly Americans receive their basic health insurance protection from Medicare, but the coverage available is less than comprehensive. In ad-

dition to an annual premium of \$343 in 1990 for Part B coverage, Medicare requires substantial cost-sharing for covered services, and no assistance is provided with prescription drugs. Most of the elderly (68 percent) have private insurance to protect against Medicare's cost-sharing requirements, but these policies are often not available or extremely costly for the 11.7 million elderly Americans with low incomes.

Although Medicaid is intended to cover premiums, cost-sharing and additional benefits for the elderly poor, restrictive income and asset levels for eligibility leave two-thirds of the poor and 90 percent of the near-poor outside Medicaid's reach. As a result, low-income elderly people are less likely to have coverage to supplement Medicare than other elderly: a third of low-income elderly people rely solely on Medicare.

Gaps in Medicare coverage, coupled with limitations in the reach of Medicaid, result in out-of-pocket payments for medical care that can be financially devastating for poor and near-poor elderly people with limited incomes. On average, low-income elderly people spend 14 percent of their per capita income on out-of-pocket costs in contrast to 7 percent of income for higher income people. Over a third of low-income elderly people incur catastrophic costs for medical care of over 15 percent of income compared to 6 percent of the non-poor; those needing hospital care are the hardest hit.

Medicaid coverage improves access to medical care for low-income elderly people. Those with Medicaid coverage use medical care services at rates comparable to elderly people with private insurance to supplement Medicare. Those with only Medicare coverage are less likely to seek physician care and use lower levels of care despite similar health care needs.

* This report prepared for the U.S. Bipartisan Commission on Comprehensive Health Care (The Pepper Commission), by Diane Rowland, Sc.D., Assistant Professor, Brookdale National Fellow, The Johns Hopkins University School of Hygiene and Public Health, Baltimore, Maryland, May 10, 1990.

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Medicaid reduces the financial burden of out-of-pocket costs for medical care. Those with full Medicaid benefits have less than \$300 in annual out-of-pocket spending compared to over \$1,000 for uncovered poor and near-poor elderly people. Premiums for private insurance are a major contributor to out-of-pocket burdens for poor and near-poor elderly people. For low-income elderly people without Medicaid, the financial burden from premium payments alone is over twice the total of out-of-pocket spending by those with Medicaid coverage.

Medicaid "buy-in" assistance helps by paying the premium and cost-sharing for Medicare services, but restrictive eligibility criteria leave most low-income elderly without coverage. The Medicare Catastrophic Coverage Act of 1988 will broaden the buy-in assistance available to poor elderly people through Medicaid. State Medicaid programs are required to make buy-in assistance available to all elderly people who have incomes below the poverty line and limited assets by 1992. Yet, gaps in coverage remain. States are not required to cover prescription drugs and poor elderly people who have more than \$4,000 in assets and near-poor elderly people will remain outside the reach of Medicaid assistance.

The scope of Medicaid protection should be further expanded to pay Medicare premiums and cost-sharing and cover prescription drugs for all low-income elderly people with incomes below 200 percent of the Federal poverty level (roughly \$12,000 in 1989). For the 3.5 million elderly people living on incomes below the poverty level, Medicaid would cover the full cost of these benefits without cost-sharing. The 8.2 million near-poor elderly people with incomes between 100 and 200 percent of the poverty level would receive comparable assistance from Medicaid, but would contribute to premium and cost-sharing obligations and prescription drug costs on a sliding scale. The cost of this proposal is estimated to be \$2.1 billion in additional Federal revenue in 1990. State matching expenditures are estimated at \$1.8 billion, for a total cost of \$3.9 billion in 1990.

Expanding Medicaid to more low-income elderly people is a highly targeted approach that would provide immediate relief from medical burdens to the most vulnerable of the elderly population. Future initiatives may look to broadening the scope of Medicare coverage for all elderly people, but in the short run Medicaid reforms directed toward the low-income population can make a measurable difference in improving access to care and alleviating the financial burdens associated with medical care services.

Fewer Resources, Greater Burdens: Medical Care Coverage for Low-Income Elderly People

One in three elderly Americans faces each day on a limited income that leaves little room for extra or unexpected expenses. When illness strikes, these poor and near-poor elderly Americans depend on Medicare for assistance with their medical bills, but Medicare does not provide complete protection. Many low-income elderly people have to struggle to finance the rest of their care from limited savings or by shifting income from other required needs.

The Medicaid program is essentially the safety net to Medicare for many poor elderly people. Once covered by Medicaid, an elderly person faces little risk of high out-of-pocket expenses. However, the impression that Medicaid supplements Medicare for all poor elderly is false. Today, only a third of poor elderly people have Medicaid coverage to fill in Medicare's cost-sharing, pay the Medicare Part B premium and provide additional benefits.

Even with the recent extension of buy-in coverage to all elderly people with incomes below the poverty level under the Medicare Catastrophic Coverage Act of 1988, protection will be less than comprehensive and many of the poor will remain vulnerable. Restrictive resource tests limit eligibility for many of the poor and others who are potentially eligible do not apply for Medicaid assistance. In part, this lack of participation results because the eligibility and benefit guidelines for Medicaid are complex and difficult to understand. If improvements in the Medicaid program are to benefit their intended population groups, effective outreach programs must be developed and eligibility rules simplified.

It is, however, near-poor elderly people who are most at-risk. Those with incomes between 100 and 200 percent of poverty, roughly \$6,000 to \$12,000 per year in 1989, are generally not eligible for Medicaid. These near-poor elderly people are especially at risk for impoverishment as a result of medical expenses, yet eligibility for the catastrophic coverage buy-in provision stops at the poverty level and offers no protection for those with incomes just above the \$5,980 poverty threshold.

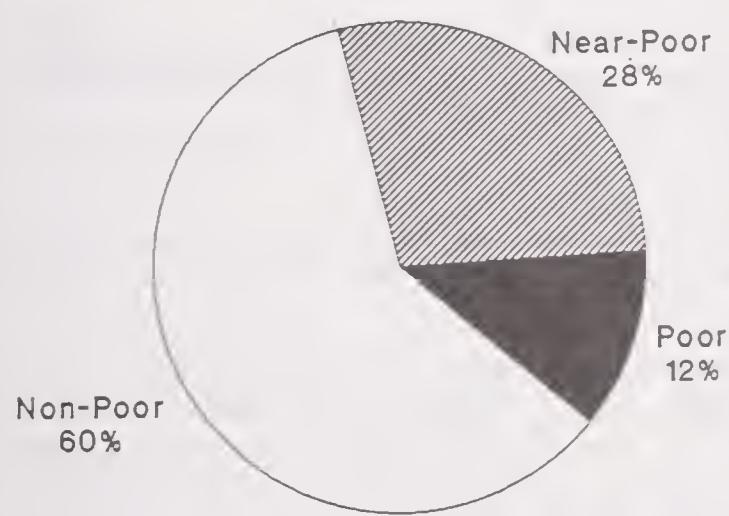
This background paper prepared for the Pepper Commission profiles the economic and health status of the elderly population, examines the financial burden associated with obtaining health care services, and offers recommendations to improve protection. Particular emphasis is given to examining the burdens

medical care expenses impose on low-income elderly people and the extent to which coverage to supplement Medicare can assist in alleviating burdens for this group. The analysis presented here focuses on the medical care expenses of elderly people living in the community and does not examine long-term care costs or the acute care costs of nursing home residents.

Poverty and Illness in the Elderly Population

Despite general improvements in the economic situation of the elderly population over the last two decades, many elderly people continue to struggle on low or modest incomes. Forty percent of the nation's 29 million elderly people living in the community have incomes less than 200 percent of the Federal poverty level—roughly \$12,000 for a single individual in 1989 (Figure 1). For these 11.7 million poor and near-poor people, living on a fixed income can become particularly difficult if poor health places additional burdens on limited finances to pay for cost-sharing under Medicare or for medical services that are not covered. Health status is thus an important component in assessing the overall economic well-being of the elderly population.

Figure 1 Distribution of the Elderly Population by Poverty Level, 1988



Total = 29.0 million elderly people

Poverty Levels:
Poor = less than 100% poverty (3.5 million)
Near-Poor = 100-199% poverty (8.2 million)
Non-Poor = 200% poverty or greater (17.3 million)

SOURCE: Congressional Budget Office estimates of the non-institutionalized elderly based on the Current Population Survey, March 1989.

Economic Status—In 1989, the federal poverty level was \$5,980 per year for an individual and \$8,020 for a couple. Twelve percent of the elderly population (3.5 million people) had incomes below this level and thus

had to meet their daily living expenses on an income of less than \$500 per month. Another 28 percent of elderly people (8.2 million people) were near-poor with incomes between 100 and 199 percent of the federal poverty level. Together, these 11.7 million poor and near-poor people comprise the low-income elderly population (Table 1).

Table 1 Distribution of the Elderly Population by Poverty Level, 1988

| | Number of People (in millions) | Percent Distribution |
|--------------------------------------|-----------------------------------|----------------------|
| Total Elderly..... | 29.0 | 100.0% |
| Poor (less than 100% poverty)..... | 3.5 | 12.0% |
| Near-Poor (100-199% poverty)..... | 8.2 | 28.4% |
| 100-149% Poverty | 4.5 | 15.6% |
| 150-199% Poverty | 3.7 | 12.8% |
| Non-Poor (200% poverty or more)..... | 17.3 | 59.6% |
| 200-299% Poverty | 6.0 | 20.8% |
| 300% Poverty or More..... | 11.3 | 38.8% |

SOURCE: Congressional Budget Office estimates of the non-institutionalized elderly population based on the Current Population Survey, March 1989.

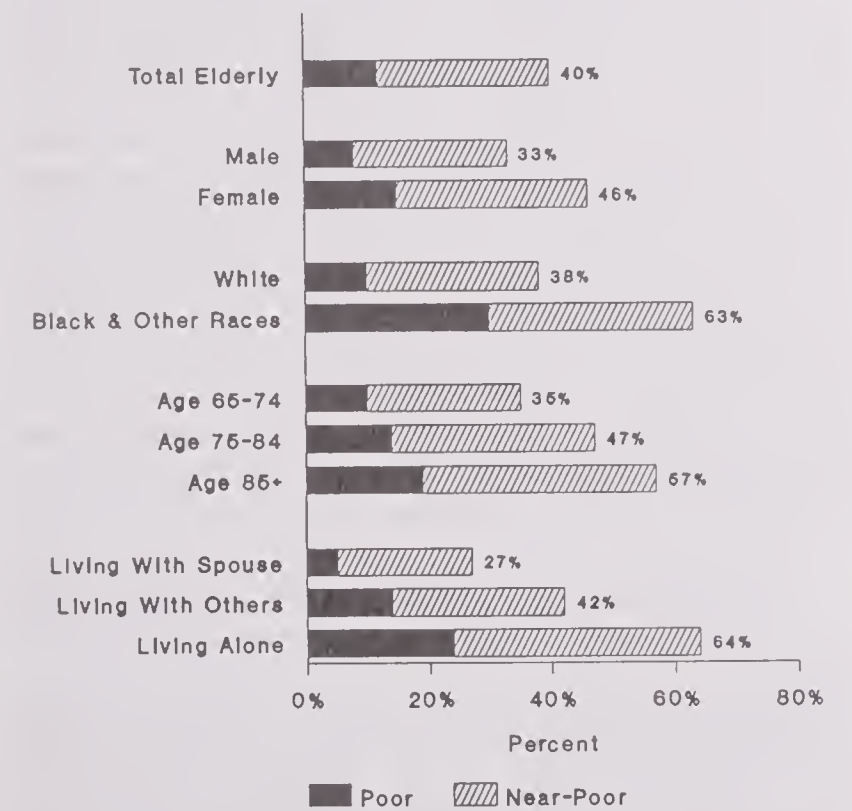
The likelihood of living on a low income is greatest for women, minorities, the oldest Americans, and those who live alone (Figure 2). Nearly half (46 percent) of elderly women and two-thirds (63 percent) of elderly minorities have incomes below twice the poverty level. The likelihood of being poor or near poor increases with age with over half (57 percent) of those age 85 and older in the low-income group compared to a third (35 percent) of 65-74 year olds. Reflecting their older age distribution, elderly people who live alone are four times as likely to be poor as those who live with a spouse. Lower educational levels and residence in rural areas and the South are also associated with economic deprivation (Table 2).

An examination of the demographic characteristics of the 3.5 million elderly people living in poverty shows the population to be predominantly female, disproportionately minority, and of advanced age (Table 3). Women comprise almost three-quarters (72 percent) of poor elderly people, reflecting their lower wage levels during working years, the increased risk of financial devastation from widowhood, and longevity that exceeds savings. Although they account for only 10 percent of all elderly people, blacks and other minorities comprise one-quarter of all poor elderly people. Sixty percent of poor elderly people live alone and are especially vulnerable in times of illness

because the financial strain caused by their low incomes is complicated by the lack of support from a spouse, resulting in the need for more services. Although their predominance in the poor population is most striking, women, minorities, and those over age 85 are also over-represented in the near-poor population.

The low-income elderly population is much more likely to rely heavily on publicly sponsored sources of income, including Social Security and Supplemental Security Income (SSI) than those who are economically better off (Commonwealth Fund Commission, 1987). In many cases, these sources of income provide just enough money to meet daily living expenses. In 1988, the average Social Security benefit provided an annual income of only \$5,800, just slightly above the Federal poverty level for an elderly individual of \$5,677. Although SSI provides cash assistance to help the low-income elderly population, the Federal SSI benefit for a single individual is 74 percent of poverty and thus does not raise an impoverished elderly person's income to the poverty level.

Figure 2 Percent of Elderly Who Are Poor or Near-Poor by Sex, Race, Age and Living Arrangement, 1988



SOURCE: Congressional Budget Office estimates of the non-institutionalized elderly based on the Current Population Survey, March 1989.

In addition to limited income, poor and near-poor elderly people have few financial assets to draw on when faced with high medical costs. Savings are not available to finance extended or expensive care. Over

80 percent of the poor have less than \$10,000 in financial assets when the family home is excluded. The near-poor also have little in the way of financial resources with three-quarters of that population having less than \$25,000 in assets (Kennell, 1990).

Table 2 Distribution of the Elderly Population by Income Level and Selected Characteristics, 1988

| | Total Elderly (Number in millions) | Total | Poor | Near-Poor | Non-Poor |
|------------------------------|---------------------------------------|--------|------------------------|------------------------|------------------------|
| | | | < 100% | 100-199% | 200% or more |
| | | | Percent Distribution * | Percent Distribution * | Percent Distribution * |
| Total..... | 29.0 | 100.0% | 12.1% | 28.3% | 59.7% |
| Age | | | | | |
| 65-74 | 17.7 | 100.0% | 10.2% | 24.9% | 65.5% |
| 75-84 | 9.2 | 100.0% | 14.1% | 32.6% | 52.2% |
| 85+ | 2.1 | 100.0% | 19.0% | 38.1% | 42.9% |
| Sex | | | | | |
| Male | 12.1 | 100.0% | 8.3% | 24.8% | 66.9% |
| Female..... | 16.9 | 100.0% | 14.8% | 30.8% | 54.4% |
| Race | | | | | |
| White..... | 26.0 | 100.0% | 10.0% | 27.7% | 62.3% |
| Black/Others | 3.0 | 100.0% | 30.0% | 33.3% | 36.7% |
| Living Arrangement | | | | | |
| Alone..... | 3.9 | 100.0% | 23.6% | 40.4% | 37.1% |
| With Spouse..... | 16.5 | 100.0% | 5.5% | 22.4% | 72.1% |
| With Others | 3.6 | 100.0% | 13.9% | 27.8% | 58.3% |
| Education | | | | | |
| Less than 8th Grade.. | 4.5 | 100.0% | 26.7% | 40.0% | 33.3% |
| 8-12th Grade | 18.3 | 100.0% | 10.9% | 30.6% | 58.5% |
| Higher than 12th Grade | 6.3 | 100.0% | 4.8% | 14.3% | 81.0% |
| Residence | | | | | |
| SMSA..... | 21.4 | 100.0% | 10.7% | 27.1% | 62.1% |
| Non-SMSA | 7.6 | 100.0% | 15.8% | 32.9% | 52.6% |
| Region | | | | | |
| Northeast..... | 6.6 | 100.0% | 10.6% | 27.3% | 62.1% |
| North Central | 7.0 | 100.0% | 10.0% | 30.0% | 61.4% |
| South | 10.0 | 100.0% | 17.0% | 30.0% | 54.0% |
| West..... | 5.4 | 100.0% | 7.4% | 25.9% | 66.7% |

* Rows of percents may not add to total due to rounding.
SOURCE: Congressional Budget Office estimates of the non-institutionalized elderly population based on the Current Population Survey, March 1989.

When illness strikes an elderly individual or their spouse, high out-of-pocket expenses can quickly deplete these limited resources. The burden of caring for a sick spouse, and perhaps ultimately shifting care to a nursing home, can exhaust the financial resources of a couple and leave the spouse remaining in the community bereft of both spouse and necessary support. Many of the women who live out their lives alone and in poverty have had their futures compromised by the illness and death of a husband. Others become

impoverished by their own medical bills as chronic care and longer life draw down economic resources.

Health Status—The burden of illness is a serious problem for many poor and near-poor elderly people. Poor health status, multiple chronic conditions and functional limitations are all more prevalent among the low-income elderly population than those with higher incomes. These conditions increase the need for and utilization of medical services which in turn increases the financial burden for cost-sharing and uncovered medical expenses.

Table 3 Characteristics of the Elderly Population by Income, 1988

| | Total | Poor | Near-Poor | Non-Poor |
|---|-------|-------|-----------|--------------|
| | | <100% | 100–199% | 200% or more |
| Total Elderly (Number in millions)..... | 29.0 | 3.5 | 8.2 | 17.3 |
| Percent Distribution | | | | |
| <i>Age</i> | | | | |
| 65–74 | 61.1 | 50.8 | 53.6 | 66.8 |
| 75–84 | 31.6 | 38.5 | 36.9 | 27.7 |
| 85+ | 7.2 | 10.7 | 9.5 | 5.5 |
| <i>Sex</i> | | | | |
| Male..... | 41.6 | 27.7 | 36.9 | 46.7 |
| Female | 58.4 | 72.3 | 63.1 | 53.3 |
| <i>Race</i> | | | | |
| White | 89.6 | 74.5 | 87.7 | 93.5 |
| Black/Others | 10.4 | 25.5 | 12.3 | 6.5 |
| <i>Living Arrangement</i> | | | | |
| Alone | 30.8 | 60.7 | 43.1 | 18.9 |
| With Spouse | 56.9 | 24.6 | 45.3 | 69.0 |
| With Others | 12.3 | 14.7 | 11.6 | 12.1 |
| <i>Education</i> | | | | |
| Less than 8th Grade | 15.4 | 35.5 | 21.3 | 8.5 |
| 8–12th Grade | 62.9 | 56.9 | 68.0 | 61.7 |
| Higher than 12th Grade ... | 21.7 | 7.6 | 10.6 | 29.8 |
| <i>Residence</i> | | | | |
| SMSA | 73.7 | 65.5 | 69.9 | 77.1 |
| Non-SMSA..... | 26.3 | 34.5 | 30.1 | 22.9 |
| <i>Region</i> | | | | |
| Northeast | 22.7 | 19.8 | 22.0 | 23.6 |
| North Central | 24.3 | 20.2 | 24.9 | 24.8 |
| South | 34.5 | 48.2 | 35.9 | 31.0 |
| West | 18.6 | 11.7 | 17.2 | 20.6 |

SOURCE: Congressional Budget Office estimates of the non-institutionalized elderly population based on the Current Population Survey, March 1989.

Poor health status has been shown to be highly predictive of the need for medical care (Manning, Newhouse and Ware, 1981). Overall, one-third of the elderly population reports their health as fair or poor, but low-income elderly people are much more likely

to have fair or poor health than those with higher incomes. Almost half (47 percent) of poor and 37 percent of near-poor elderly people report their health as fair or poor compared to 25 percent of non-poor elderly people (Figure 3).

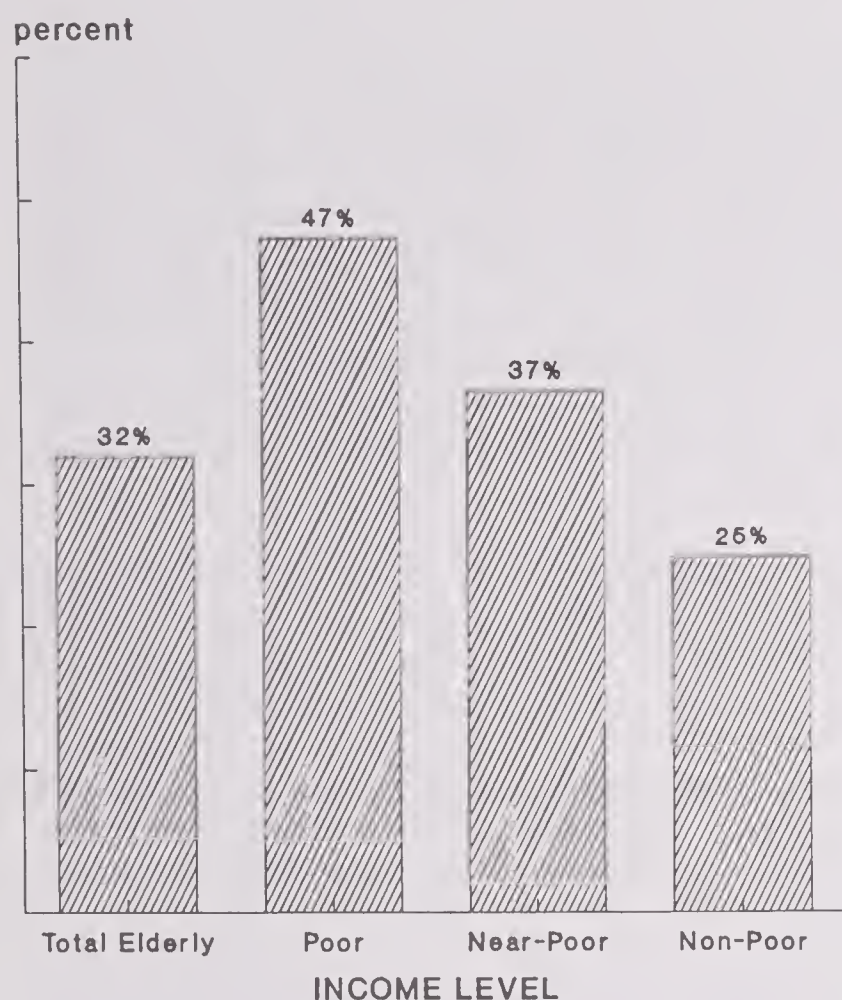
Chronic conditions are more prevalent in the elderly population than in the non-elderly population, but are particularly burdensome for low-income elders. Low-income people are more likely to have arthritis, hypertension, and vision problems than non-poor elderly people (Figure 4). For example almost two-thirds (62 percent) of poor elderly people suffer from arthritis that can impair mobility and result in the need for medication for treatment and pain relief. The prevalence is lower for the near-poor (53 percent) and lowest for the non-poor (48 percent) elderly population.

Over half of poor elderly people have hypertension, 17 percent have heart disease, and 9 percent have cerebrovascular disease (Table 4). The occurrence of these chronic conditions is consistently higher among the poor elderly than the near-poor or the non-poor. These conditions require physician monitoring and prescription drugs to maintain health status. Thirteen percent of poor elderly people have diabetes and most require insulin treatment as well as medical care for the many conditions that arise as complications to diabetes. Vision and hearing problems also afflict over 40 percent of poor elderly people. Although correctional aids can vastly improve functional ability and quality of life, they can be quite costly.

Functional disabilities contributing to the need for long-term care assistance further compound the medical problems of elderly people (Rowland, 1989). Twenty-one percent of poor elderly people report being restricted in one or more activities of daily living compared to 15 percent of the near-poor and 12 percent of the non-poor. Elderly people with functional impairments are likely to be strained financially by non-medical needs and expenses, as well as by the need for additional services and special transportation arrangements to obtain medical care.

In sum, poor and near-poor elderly people are more likely to be experiencing health problems for which they require medical services than elderly people who are economically better off, but they are less able to afford needed care because of their lower incomes. For those who need medical care and incur large out-of-pocket expenditures, medical expenses can lead to impoverishment. The extent to which insurance is available to assist with medical bills becomes a crucial factor.

Figure 3 Percent of Elderly People Reporting Fair or Poor Health by Income, 1984



SOURCE: Johns Hopkins University estimates of the non-institutionalized elderly based on the 1984 Supplement on Aging to the National Health Interview Survey.

Health Insurance Coverage

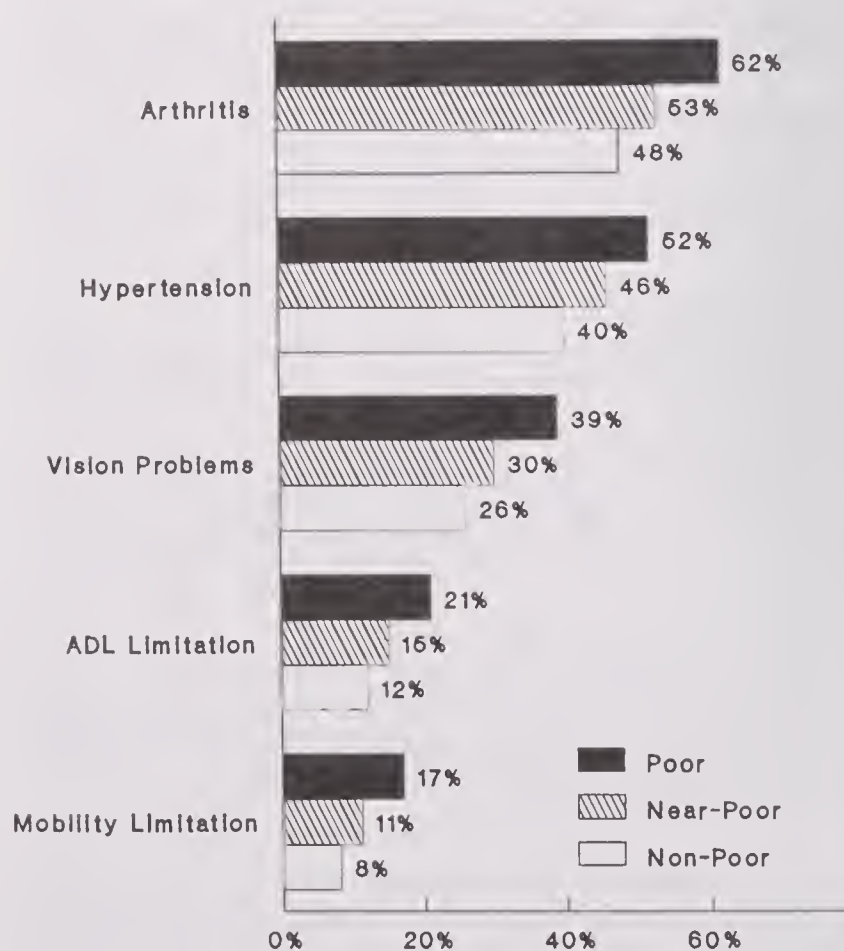
Nearly all elderly Americans receive their basic health insurance protection from Medicare. The design and scope of the Medicare benefit package was modeled after private health insurance coverage for the under-65 population with substantial coinsurance and deductibles. The Hospital Insurance (Part A) component provides fairly extensive coverage of short-term hospital care and limited coverage of post-acute skilled nursing facility and home health services. The Supplementary Medical Insurance (Part B) component of Medicare covers physician care and related ambulatory services and home health visits. Medicare beneficiaries are required to pay a premium for coverage under Part B.

The actual level of insurance protection among the elderly population varies substantially because many elderly people have private insurance and/or Medicaid to supplement their Medicare coverage (Figure 5). Almost 70 percent of elderly people have private

supplemental insurance, often called Medigap insurance, in addition to their Medicare coverage. An additional eight percent of elderly people receive assistance from Medicaid because they are low income. Nearly a quarter (22 percent) of the elderly population is without supplementary coverage and relies solely on Medicare. They pay out-of-pocket for Medicare cost-sharing and the cost of uncovered services. One percent of the elderly population is uninsured.

The uninsured elderly population is a group of 300,000 elderly people who are without Medicare or any other health insurance coverage (Table 5). Medicare coverage is linked to eligibility for Social Security through one's own or a spouse's work history. Elderly people who have not participated in the Social Security program or who have not accrued an adequate work history may not be entitled to Medicare benefits. For them, the cost of buying Medicare or private coverage may be prohibitive. As a result, America's uninsured population also includes a small group of elderly people.

Figure 4 Percent of Elderly Population With Selected Conditions, 1984



SOURCE: Johns Hopkins University estimates of the non-institutionalized elderly based on the 1984 Supplement on Aging to the National Health Interview Survey.

Table 4 Health Status, Medical Conditions and Other Related Problems of the Elderly Population, 1984

| | Total | Poor | Near-Poor | Non-Poor |
|---|-------|--------|-----------|--------------|
| | | < 100% | 100-199% | 200% or more |
| Percent of Elderly With Following Conditions: | | | | |
| Fair or Poor Health | 32.0 | 47.3 | 36.5 | 24.9 |
| Chronic Conditions | | | | |
| Arthritis..... | 51.6 | 62.1 | 53.0 | 47.9 |
| Hypertension..... | 43.6 | 51.8 | 45.9 | 39.9 |
| Heart Disease | 16.0 | 17.0 | 16.2 | 15.6 |
| Diabetes..... | 10.0 | 13.3 | 10.8 | 8.5 |
| Cerebrovascular Disease..... | 6.5 | 9.0 | 7.1 | 5.4 |
| Other Related Problems | | | | |
| ADL Limitation *..... | 14.2 | 21.2 | 15.0 | 11.7 |
| IADL Limitation ** | 14.1 | 22.9 | 15.6 | 10.7 |
| Mobility Difficulty..... | 10.1 | 17.3 | 10.7 | 7.8 |
| Hearing Problems..... | 37.5 | 42.0 | 39.0 | 35.3 |
| Vision Problems..... | 29.4 | 39.0 | 30.4 | 26.2 |

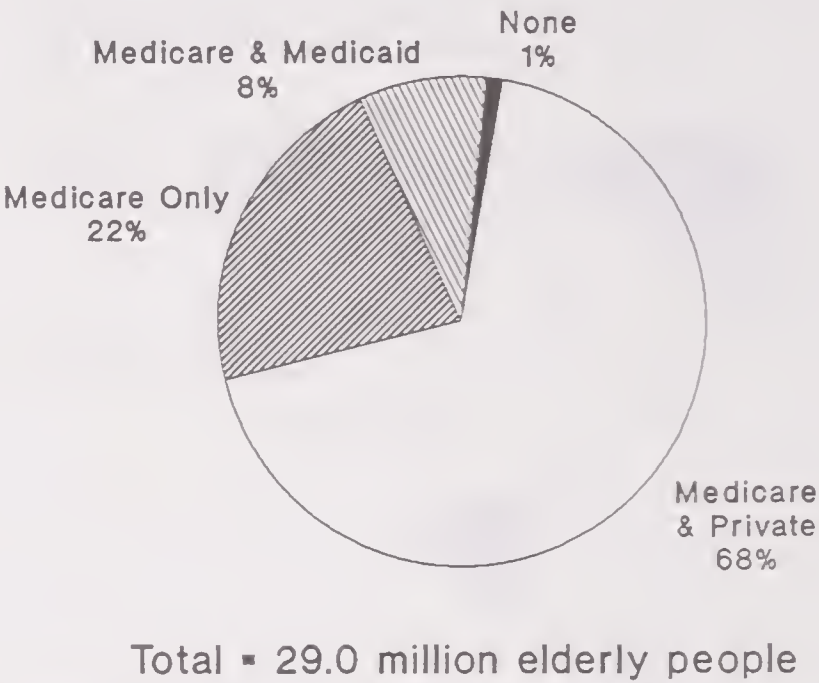
* Limited in one or more of the following ADLs: Bathing, dressing, transferring, eating, or toileting.
** Limited in one or more of the following IADLs: Shopping, making meals, managing money or using the telephone.

SOURCE: Johns Hopkins University estimates of the non-institutionalized elderly population based on the 1984 Supplement on Aging to the National Health Interview Survey.

The pattern of insurance coverage varies significantly by income with private insurance to complement Medicare most common among the non-poor elderly population and less extensive as a form of financing for the elderly poor (Figure 6). Among the poor elderly, one-third (34 percent) have Medicare and private coverage, one-third (34 percent) rely solely on Medicare, 29 percent have Medicare and Medicaid, and three percent are uninsured. For the near-poor elderly population, private coverage is more extensive with 59 percent reporting such coverage while 10 percent have Medicaid and 31 percent rely solely on Medicare. Among the non-poor population, 80 percent have both Medicare and private coverage and only 16 percent rely solely on Medicare.

In addition to the small group of uninsured elderly people, the group with Medicare-only coverage also faces substantial risk for out-of-pocket spending when illness strikes and cost-sharing levels under Medicare mount. Among the 29 million elderly Americans living in the community, 6.5 million rely solely on Medicare (Table 6). Low-income elderly people comprise 57 percent of the Medicare-only population. Thus, any efforts at filling gaps in supplementary coverage will result in substantial assistance to the low-income elderly population.

Figure 5 Health Insurance Coverage of Elderly People, 1988



SOURCE: Congressional Budget Office estimates of the non-institutionalized elderly based on the Current Population Survey, March 1989.

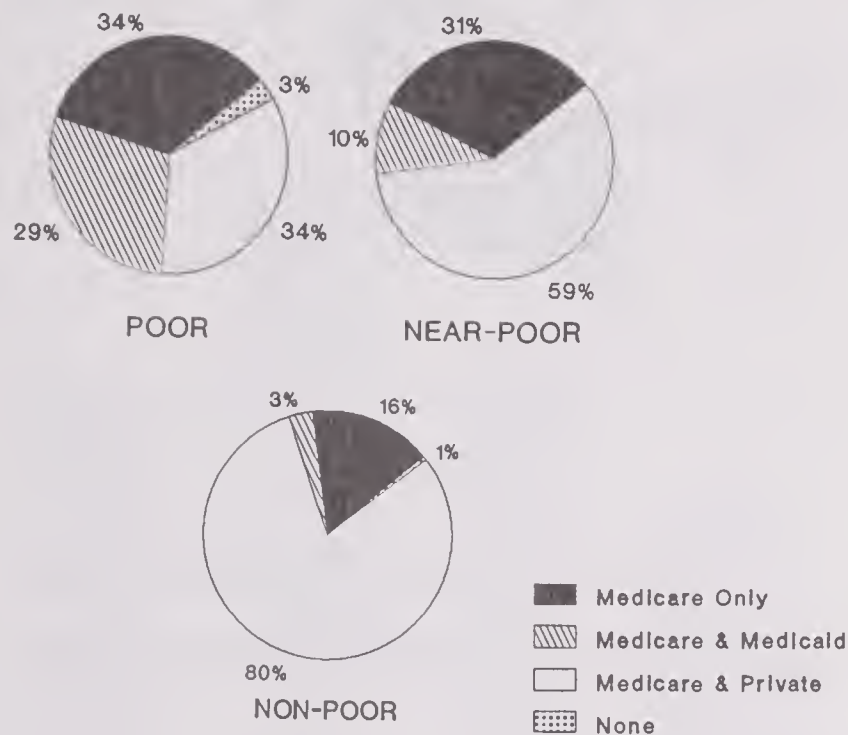
Table 5 Health Insurance Coverage of the Elderly Population, 1988

| | Number of People | Percent Distribution |
|------------------------------------|------------------|----------------------|
| | (in millions) | |
| Total Elderly..... | 29.0 | 100.0% |
| Medicare & Medicaid | 2.4 | 8.3% |
| Medicare & Medicaid Only | 1.9 | 6.6% |
| Medicare & Medicaid & Private..... | 0.5 | 1.7% |
| Medicare & Private..... | 19.8 | 68.3% |
| Medicare & Private | 18.8 | 64.9% |
| Only Private..... | 1.0 | 3.4% |
| Medicare Only..... | 6.5 | 22.4% |
| None | 0.3 | 1.0% |

SOURCE: Congressional Budget Office estimates of the non-institutionalized elderly population based on the Current Population Survey, March 1989.

Private Supplementary Insurance—The most common insurance protection arrangement for elderly people combines Medicare and private insurance coverage to help with Medicare cost-sharing. Private supplementary policies vary considerably in the amount of coverage provided. Coverage of the Medicare copayments is standard and some policies also cover deductibles and other items, such as prescription drugs, that are not covered or partially covered by Medicare (Rice and McCall, 1985).

Figure 6 Health Insurance Coverage of Elderly People by Income, 1988



SOURCE: Congressional Budget Office estimates of the non-institutionalized elderly based on the Current Population Survey, March 1989.

The comprehensiveness and cost of private supplemental insurance is related to how an elderly individual obtains this coverage. Forty-six percent of those with private supplemental insurance obtain coverage under group policies from current or former employers (Monheit and Schur, 1989). In most of these situations, the employer pays some or all of the cost of the insurance policy as a retirement benefit. The other 54 percent of elderly people with private supplemental coverage purchase individual policies themselves. Both group and nongroup insurance policies cover nearly all hospital and inpatient physician care, but individual policies tend to provide less coverage for other services, particularly outpatient diagnostic care and prescribed medicines, dental care and mental health. The cost of individual policies is high, ranging from about \$500 to \$1,300 per year (Consumer's Union 1989).

The high cost of private coverage results in low-income elderly people being less likely to purchase private insurance coverage than more economically advantaged elderly people. Low income elderly people are also less likely to have had the types of jobs during their working years that offer private health insurance coverage after retirement as a benefit. As a result, 80 percent of non-poor elderly people have private insurance compared to 34 percent of poor and 58 percent of near-poor elderly people.

With basic policies costing more than \$500 per year, it is striking that a third of poor elderly people are potentially committing over 10 percent of their incomes just to pay the premiums for private insurance coverage. The near-poor elderly population is also financially pressed, yet over half elect to purchase private coverage.

Table 6 Health Insurance Coverage of the Elderly Population by Income, 1988

| | Total * | Poor | Near-Poor | Non-Poor |
|--|---------|--------|-----------|--------------|
| | | <100% | 100-199% | 200% or more |
| Total Elderly (Number in millions) | 29.0 | 3.5 | 8.2 | 17.3 |
| Medicare Only | 6.5 | 1.2 | 2.5 | 2.7 |
| Medicare & Private ** | 19.8 | 1.2 | 4.8 | 13.8 |
| Medicare & Medicaid *** | 2.4 | 1.0 | 0.8 | 0.6 |
| None..... | 0.3 | 0.1 | 0.0 | 0.1 |
| PERCENT DISTRIBUTION | | | | |
| Total Elderly | 100.0% | 100.0% | 100.0% | 100.0% |
| Medicare Only | 22.4% | 34.3% | 30.5% | 15.6% |
| Medicare & Private | 68.3% | 34.3% | 58.5% | 79.8% |
| Medicare & Medicaid..... | 8.3% | 28.6% | 9.8% | 3.5% |
| None..... | 1.0% | 2.9% | 0.0% | 0.6% |
| Total Elderly | 100.0% | 12.1% | 28.3% | 59.7% |
| Medicare Only | 100.0% | 18.5% | 38.5% | 41.5% |
| Medicare & Private | 100.0% | 6.1% | 24.2% | 69.7% |
| Medicare & Medicaid..... | 100.0% | 41.7% | 33.3% | 25.0% |
| None..... | 100.0% | 33.3% | 0.0% | 33.3% |

* Total may not add due to rounding.
** Some individuals, such as federal or state employees, have insurance other than Medicare.
*** Some individuals also have private insurance.
SOURCE: Congressional Budget Office estimates of the non-institutionalized elderly population based on the Current Population Survey, March 1989.

Medicaid Coverage—One of the reasons poor and near-poor elderly people turn to private insurance is that many are unable to obtain assistance from Medicaid. Overall, eight percent of all elderly people receive assistance from Medicaid to supplement Medicare's coverage of medical expenses. For these people, the Medicaid program functions like a private insurance supplementary policy by filling in Medicare's cost-sharing. However, Medicaid coverage provides better protection by also paying the Part B

Medicare premium and covering additional benefits, most notably prescription drugs. For the most part, the Medicaid program thus provides more comprehensive benefits to supplement Medicare than private insurance policies and eliminates the need to pay premiums for either Medicare or private coverage.

Although the Medicaid program provides important coverage for some of the poorest elderly people, the impression that Medicaid supplements Medicare for all poor elderly people is false. In fact, the portion of the poor with Medicaid is the same as the portion with private insurance. Less than one-third (29 percent) of poor elderly people and 10 percent of near-poor elderly people have Medicaid coverage.

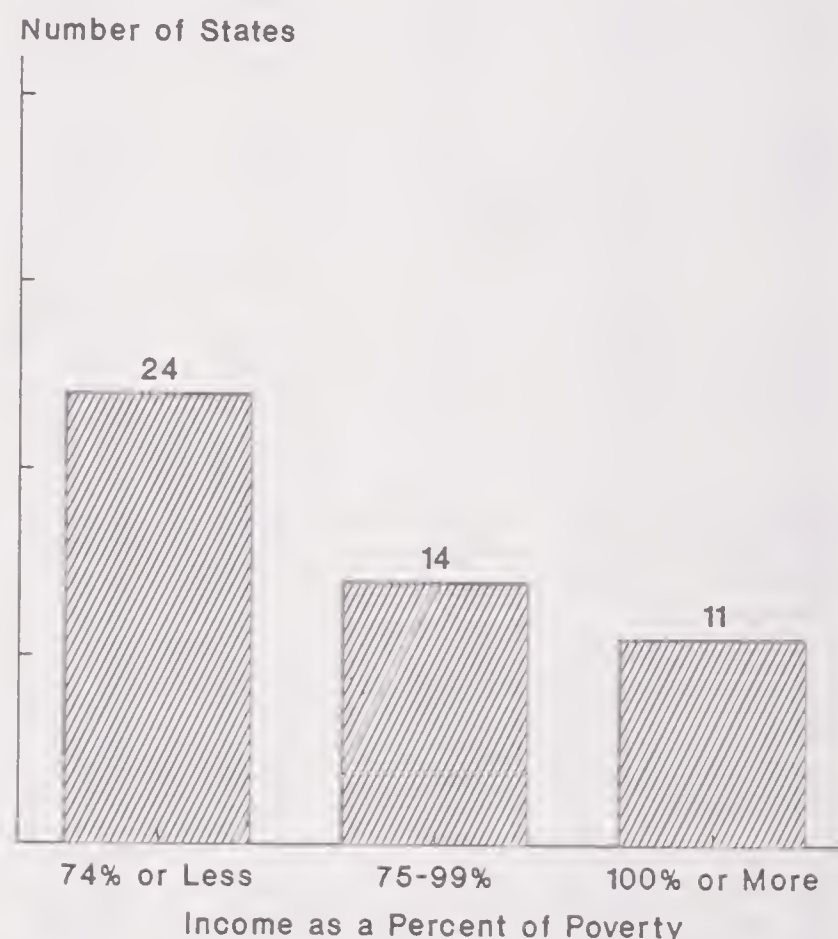
There are several reasons why Medicaid falls short in assisting low-income elderly people. First, Medicaid eligibility for elderly people is shaped predominantly by Federal policy under the Supplemental Security Income (SSI) program which provides cash assistance to elderly and disabled persons. Because of the link to welfare, individuals must meet stringent income and asset eligibility criteria to obtain Medicaid coverage. Only 11 states set their Medicaid eligibility level at or above the poverty level (Figure 7).

The average income standard for a single elderly individual under Medicaid in 1989 was 83 percent of poverty or \$4,956 per year, but income eligibility criteria vary widely among states (Table 7). Most states provide Medicaid eligibility to those who meet the income criteria for receipt of cash assistance, although some employ higher standards for Medicaid under an option in the 1986 Omnibus Budget Reconciliation Act. The level ranges from a low of \$2,904 (49 percent of poverty) per individual in North Carolina to a high of \$8,796 (147 percent of poverty) in Vermont. An income of \$5,000 is too generous for an elderly individual to obtain Medicaid eligibility in most states. For couples, the average income standard for Medicaid is 88 percent of poverty or \$7,037 (Table 8). Again the standard varies widely among states from \$3,696 or 46 percent of poverty in North Carolina to \$13,392 or 167 percent of poverty in California.

In 35 states elderly people with higher incomes can qualify for Medicaid assistance under the medically needy program option. In these states, if medical expenses reduce income to below the medically needy income level, individuals obtain Medicaid coverage. However, medically needy levels are set in relation to state standards for Aid to Families with Dependent

Children coverage and are lower than general Medicaid eligibility levels for the elderly and disabled. Thus, those with medical expenses must actually spend-down to a lower income standard than those eligible as SSI cash assistance recipients. Medically needy levels average 71 percent of poverty for individuals and 65 percent of poverty for couples.

Figure 7 State Medicaid Eligibility Criteria for Elderly Individuals,* 1989



*Federal SSI benefit for elderly individuals is set at 74% of poverty.

SOURCE: Rowland, Salganicoff, and Lyons, 1990.

In addition to income limits, Medicaid also has severe asset limitations for eligibility. Houses are excluded from resource limits, but savings and other possessions are not. Generally, to qualify for Medicaid eligibility, assets cannot exceed \$2,000 for individuals and \$3,000 for couples (Table 9). A few states have relaxed the asset limit to \$5,000 for individuals and \$6,000 for couples, but in most cases, the lower standard applies. These asset levels are so stringent that less than half of the elderly poor and a quarter of the near-poor can meet the asset test for Medicaid (Kennell, 1990).

Table 7 Medicaid Income Eligibility Limits for Elderly Individuals, 1989

| State | Full Medicaid Benefits | | Medically Needy Coverage | | Buy-in Only | |
|----------------------------|------------------------|-------------------------------------|--------------------------|---------------------------------|--------------|---------------------------------|
| | Income Level | Income as Percentage of Poverty (a) | Income Level | Income as Percentage of Poverty | Income Level | Income as Percentage of Poverty |
| Average | \$4,956 | (b) 83% | \$4,257 | 71% | \$5,259 | 88% |
| Alabama..... | \$4,416 | 74% | — | — | \$5,076 | 85% |
| Alaska | \$8,220 | 110% ** | — | — | \$7,476 | 100% |
| Arizona..... | \$5,088 | 85% ** | — | — | \$5,088 | 85% |
| Arkansas..... | \$4,416 | 74% | \$1,296 | 22% | \$5,088 | 85% |
| California..... | \$7,224 | 121% | \$7,200 | 120% | (c) | |
| Colorado | \$5,112 | 85% | — | — | \$5,088 | 85% |
| Connecticut * | \$6,672 | 112% | \$5,424 | 91% | \$5,088 | 85% |
| Delaware..... | \$4,416 | 74% | — | — | (c) | |
| District of Columbia | \$5,976 | 100% ** | \$4,692 | 78% | \$5,976 | 100% |
| Florida | \$5,976 | 100% ** | \$3,600 | 59% | \$5,976 | 100% |
| Georgia | \$4,416 | 74% | — | — | \$5,076 | 85% |
| Hawaii * | \$6,864 | 100% ** | \$4,284 | 62% | \$6,864 | 100% |
| Idaho | \$5,052 | 86% | — | — | \$5,088 | 85% |
| Illinois * | NA | NA | \$3,204 | 54% | \$4,788 | 80% |
| Indiana * | \$4,416 | 74% | — | — | \$4,620 | 77% |
| Iowa..... | \$4,416 | 74% | \$5,592 | 94% | \$5,076 | 85% |
| Kansas..... | \$4,416 | 74% | \$4,416 | 74% | \$5,088 | 85% |
| Kentucky..... | \$4,416 | 74% | \$2,604 | 44% | \$5,088 | 85% |
| Louisiana | \$4,656 | 78% | \$1,200 | 20% | \$5,088 | 85% |
| Maine | \$5,976 | 100% ** | \$4,800 | 80% | \$5,088 | 85% |
| Maryland | \$4,416 | 74% | \$4,500 | 75% | \$5,100 | 85% |
| Massachusetts | \$5,976 | 100% ** | \$5,976 | 100% | \$5,976 | 100% |
| Michigan | \$5,076 | 85% ** | \$4,788 | 80% | \$5,076 | 85% |
| Minnesota * | \$4,416 | 74% | \$4,824 | 81% | \$5,088 | 85% |
| Mississippi | \$5,088 | 85% ** | — | — | \$5,088 | 85% |
| Missouri * | \$4,416 | 74% | — | — | \$5,076 | 85% |
| Montana..... | \$4,416 | 74% | \$4,416 | 74% | \$5,088 | 85% |
| Nebraska * | \$5,100 | 85% ** | \$4,704 | 79% | \$5,100 | 85% |
| Nevada | \$4,848 | 81% | — | — | \$5,976 | 100% |
| New Hampshire * | \$4,584 | 77% | \$4,584 | 77% | \$5,088 | 85% |
| New Jersey..... | \$5,976 | 100% ** | \$4,200 | 70% | \$5,976 | 100% |
| New Mexico..... | \$4,416 | 74% | — | — | \$5,088 | 85% |
| New York..... | \$5,508 | 92% | \$5,508 | 92% | \$5,988 | 100% |
| North Carolina * | \$2,904 | 49% | \$2,904 | 49% | \$4,776 | 80% |
| North Dakota * | \$4,416 | 74% | \$4,140 | 69% | \$5,088 | 85% |
| Ohio * | \$3,768 | 63% | — | — | \$4,788 | 80% |
| Oklahoma * | \$5,184 | 87% | \$3,300 | 55% | \$5,388 | 90% |
| Oregon..... | \$4,436 | 74% | \$4,620 | 77% | \$5,088 | 85% |
| Pennsylvania | \$5,976 | 100% ** | \$4,896 | 82% | \$5,976 | 100% |
| Rhode Island..... | \$5,148 | 86% | \$6,600 | 110% | \$5,088 | 85% |
| South Carolina | \$4,416 | 74% | — | — | \$5,976 | 100% |
| South Dakota | \$4,416 | 74% | — | — | \$5,088 | 85% |
| Tennessee..... | \$4,416 | 74% | \$2,100 | 35% | \$5,088 | 85% |
| Texas | \$4,416 | 74% | — | — | \$5,088 | 85% |
| Utah..... | \$4,416 | 74% | \$4,044 | 68% | \$5,976 | 100% |
| Vermont | \$8,796 | 147% ** | \$8,796 | 147% | \$5,139 | 86% |
| Virginia * | \$4,416 | 74% | \$3,000 | 50% | \$5,088 | 85% |
| Washington | \$4,752 | 79% | \$4,752 | 79% | \$5,088 | 85% |
| West Virginia | \$4,416 | 74% | \$2,400 | 40% | \$5,076 | 85% |
| Wisconsin | \$5,652 | 95% | \$5,652 | 95% | \$5,976 | 100% |
| Wyoming..... | \$4,656 | 78% | — | — | \$5,316 | 89% |

NOTES:

* 209(b) states; may use more restrictive criteria than the SSI standard (\$4,416 per year for individuals at 74% of poverty) to determine Medicaid eligibility.

** 1986 OBRA eligibility level used.

— Signifies option not covered by state.

NA Information was not available.

(a) Eligibility criteria is the higher of either state categorically needy or OBRA 1986 Buy-in eligibility criteria.

(b) The Official Federal Poverty level for 1989 is \$5,980/year for individuals, except in Alaska (\$7,475/year) and Hawaii (\$6,877/year).

(c) Not effective until January 1, 1990.

SOURCE: Rowland, Salganicoff, and Lyons, 1990.

Table 8 Medicaid Income Eligibility Limits for Elderly Couples, 1989

| State | Full Medicaid Benefits | | Medically Needy Coverage | | Buy-in Only | |
|----------------------------|------------------------|-------------------------------------|--------------------------|---------------------------------|--------------|---------------------------------|
| | Income Level | Income as Percentage of Poverty (a) | Income Level | Income as Percentage of Poverty | Income Level | Income as Percentage of Poverty |
| Average | \$7,037 | (b) 88% | \$5,225 | 65% | \$6,897 | 86% |
| Alabama..... | \$6,636 | 83% | — | — | \$6,804 | 85% |
| Alaska | \$12,180 | 121% ** | — | — | \$8,820 | 88% |
| Arizona..... | \$6,828 | 85% ** | — | — | \$6,828 | 85% |
| Arkansas..... | \$6,636 | 83% | \$2,604 | 32% | \$6,816 | 85% |
| California..... | \$13,392 | 167% | \$11,208 | 140% | (c) | |
| Colorado | NA | NA | — | — | \$6,828 | 85% |
| Connecticut * | \$8,556 | 107% | \$7,212 | 90% | \$6,828 | 85% |
| Delaware..... | \$6,636 | 83% | — | — | (c) | |
| District of Columbia | \$8,196 | 102% ** | \$4,944 | 62% | \$8,016 | 100% |
| Florida | \$8,020 | 100% ** | \$3,600 | 45% | \$8,020 | 100% |
| Georgia | \$6,636 | 83% | — | — | \$6,816 | 85% |
| Hawaii * | \$9,216 | 100% ** | \$5,760 | 62% | \$9,216 | 100% |
| Idaho | \$6,936 | 86% | — | — | \$6,816 | 85% |
| Illinois * | NA | NA | \$3,996 | 50% | \$6,420 | 80% |
| Indiana * | \$6,636 | 83% | — | — | \$6,192 | 69% |
| Iowa..... | \$6,636 | 83% | \$5,592 | 70% | \$6,816 | 85% |
| Kansas..... | \$6,636 | 83% | \$5,700 | 71% | \$6,816 | 85% |
| Kentucky..... | \$6,636 | 83% | \$3,204 | 40% | \$6,816 | 85% |
| Louisiana | \$6,876 | 86% | \$2,304 | 29% | \$7,512 | 94% |
| Maine | \$8,016 | 100% ** | \$5,292 | 66% | \$6,816 | 85% |
| Maryland | \$6,636 | 83% | \$5,004 | 62% | \$6,900 | 85% |
| Massachusetts..... | \$8,016 | 100% ** | \$8,016 | 100% | \$8,016 | 100% |
| Michigan | \$7,176 | 89% ** | \$6,696 | 83% | \$6,816 | 85% |
| Minnesota * | \$6,636 | 83% | \$6,024 | 75% | \$6,828 | 85% |
| Mississippi | \$6,828 | 85% ** | — | — | \$6,828 | 85% |
| Missouri * | \$6,636 | 83% | — | — | \$6,816 | 85% |
| Montana..... | \$6,636 | 83% | \$4,596 | 77% | \$6,816 | 85% |
| Nebraska * | \$7,176 | 89% ** | \$4,704 | 59% | \$6,828 | 85% |
| Nevada | \$7,524 | 94% | — | — | (d) | |
| New Hampshire * | \$6,648 | 83% | \$6,648 | 83% | \$6,828 | 85% |
| New Jersey..... | \$8,016 | 100% ** | \$5,196 | 65% | \$8,016 | 100% |
| New Mexico..... | \$6,636 | 83% | — | — | \$6,828 | 85% |
| New York..... | \$7,908 | 99% | \$7,908 | 99% | \$8,028 | 100% |
| North Carolina * | \$3,696 | 46% | \$3,696 | 46% | \$6,408 | 80% |
| North Dakota * | \$6,636 | 83% | \$4,800 | 60% | \$6,828 | 85% |
| Ohio * | \$6,636 | 83% | — | — | \$6,420 | 80% |
| Oklahoma * | \$8,172 | 102% | \$4,092 | 51% | \$7,224 | 90% |
| Oregon | \$6,571 | 82% | \$5,892 | 73% | \$6,816 | 85% |
| Pennsylvania | \$8,016 | 100% ** | \$5,100 | 64% | \$8,016 | 100% |
| Rhode Island..... | \$8,016 | 100% | \$7,104 | 89% | \$6,816 | 85% |
| South Carolina | \$6,636 | 83% | — | — | \$8,016 | 100% |
| South Dakota | \$6,636 | 83% | — | — | \$6,828 | 85% |
| Tennessee..... | \$6,636 | 83% | \$2,304 | 29% | \$6,828 | 85% |
| Texas | \$6,636 | 83% | — | — | \$6,828 | 85% |
| Utah..... | \$6,636 | 83% | \$4,956 | 62% | \$8,016 | 100% |
| Vermont | \$8,796 | 110% ** | \$8,796 | 110% | \$6,897 | 86% |
| Virginia * | \$6,636 | 83% | \$3,696 | 46% | \$6,816 | 85% |
| Washington | \$6,900 | 86% | \$6,384 | 80% | \$6,816 | 85% |
| West Virginia | \$6,636 | 83% | \$3,300 | 41% | \$6,816 | 85% |
| Wisconsin | \$8,616 | 107% | \$7,092 | 88% | \$8,016 | 100% |
| Wyoming..... | \$6,876 | 86% | — | — | \$7,056 | 88% |

NOTES:
 * 209(b) states; may use more restrictive criteria than the SSI standard (\$6,636 per year for couples at 83% of poverty) to determine Medicaid eligibility.
 ** 1986 OBRA eligibility level used.
 — Signifies option not covered by state.
 NA Information was not available.
 (a) Eligibility criteria is the higher of either state categorically needy or 1986 OBRA Buy-in eligibility criteria.
 (b) The Official Federal Poverty level for 1989 is \$8,020/year for couples, except in Alaska (\$10,025/year) and Hawaii (\$9,223/year).
 (c) Not effective until January 1, 1990.
 (d) Nevada does not use a separate eligibility level for couples.

SOURCE: Rowland, Salganicoff, and Lyons, 1990.

Table 9 Medicaid Resource Eligibility Limits for the Elderly Population, 1989

| State | Individuals | Couples |
|---------------------------|-------------|-----------|
| Average..... | \$2,242 | \$3,384 |
| Alabama..... | \$2,000 | \$3,000 |
| Alaska..... | \$2,000 | \$3,000 |
| Arizona..... | \$2,000 | \$3,000 |
| Arkansas..... | \$2,000 | \$3,000 |
| California..... | \$2,000 | \$3,000 |
| Colorado..... | \$2,000 | \$3,000 |
| Connecticut *..... | \$1,600 | \$2,400 |
| Delaware..... | \$2,000 | \$3,000 |
| District of Columbia..... | \$2,600** | \$3,000 |
| Florida..... | \$5,000** | \$6,000** |
| Georgia..... | \$2,000 | \$3,000 |
| Hawaii *..... | \$2,000 | \$3,000 |
| Idaho..... | \$2,000 | \$3,000 |
| Illinois *..... | \$2,000 | \$3,000 |
| Indiana *..... | \$1,500 | \$2,250 |
| Iowa..... | \$5,000** | \$7,500** |
| Kansas..... | \$2,000 | \$3,000 |
| Kentucky *..... | \$2,000** | \$4,000** |
| Louisiana..... | \$2,000 | \$3,000 |
| Maine..... | \$2,000 | \$3,000 |
| Maryland..... | \$2,500** | \$3,000** |
| Massachusetts..... | \$2,000 | \$3,000 |
| Michigan..... | \$2,000 | \$3,000 |
| Minnesota *..... | \$3,000 | \$6,000 |
| Mississippi..... | \$2,000 | \$3,000 |
| Missouri *..... | \$1,000 | \$2,000 |
| Montana..... | \$2,000 | \$3,000 |
| Nebraska *..... | \$2,000 | \$3,000 |
| Nevada..... | \$2,000 | \$3,000 |
| New Hampshire *..... | \$2,500** | \$4,000** |
| New Jersey..... | \$4,000** | \$6,000** |
| New Mexico..... | \$2,000 | \$3,000 |
| New York..... | \$3,250 | \$4,950 |
| North Carolina *..... | \$1,500 | \$2,250 |
| North Dakota *..... | \$3,000** | \$6,000** |
| Ohio *..... | \$1,500 | \$2,250 |
| Oklahoma *..... | \$2,000 | \$3,000 |
| Oregon..... | \$2,000 | \$3,000 |
| Pennsylvania..... | \$2,400** | \$3,000 |
| Rhode Island..... | \$4,000** | \$6,000** |
| South Carolina..... | \$2,000 | \$3,000 |
| South Dakota..... | \$2,000 | \$3,000 |
| Tennessee..... | \$2,000 | \$3,000 |
| Texas..... | \$2,000 | \$3,000 |
| Utah..... | \$2,000 | \$3,000 |
| Vermont..... | \$2,000 | \$3,000 |
| Virginia *..... | \$2,000 | \$3,000 |
| Washington..... | \$2,000 | \$3,000 |
| West Virginia..... | \$2,000 | \$3,000 |
| Wisconsin..... | \$2,000 | \$3,000 |
| Wyoming..... | \$2,000 | \$3,000 |

* 209(b) States may use more restrictive criteria than the SSI standard (\$2,000 in resources for individual) in determining eligibility for Medicaid.

** Where state has a Medically Needy program with a higher resource standard than Categorically Needy program, the higher standard is reported.

SOURCE: Rowland, Salganicoff, and Lyons, 1990.

The "Medicare buy-in" provisions of the Medicare Catastrophic Coverage Act of 1988 will help expand

the protection available to poor elderly people under the Medicaid program (Christensen and Kasten, 1988). As of July 1992, all states will be required to provide Medicaid coverage for Medicare premiums and cost-sharing to all elderly individuals and couples with incomes below the poverty level and assets of less than \$4,000 for individuals and \$6,000 for couples. The new asset levels are twice as high as the SSI resource standards. This provision was retained despite the repeal of most of the other parts of the Catastrophic Coverage legislation.

Under the Medicare buy-in provision, states provide financial assistance to beneficiaries by paying the Medicare Part B premium as well as deductibles and coinsurance arising from use of covered medical services. Those covered by "buy-in" are referred to as "qualified Medicare beneficiaries or QMBs." These individuals, however, are still not eligible for full Medicaid benefits, including services such as prescription drugs and hearing and vision care. Thus, the buy-in population has less comprehensive coverage than those who are entitled to full benefits (Rowland, Salganicoff, and Lyons, 1989).

Medicaid assistance to poor elderly people is limited because participation rates are low. It is estimated that half of beneficiaries potentially eligible for SSI and Medicaid coverage do not enroll (Commonwealth Fund Commission, 1987). About half of those not participating appear to be unaware of the program or of their own potential eligibility. Many elderly people do not appear to understand the benefits available under Medicaid and others are reluctant to apply to a welfare-based program.

Medicaid provides even more limited assistance to the near-poor. Only 11 states cover individuals with incomes at or above the poverty level and no states provide assistance to individuals with incomes over 150 percent of poverty. As a result, only 10 percent of the near-poor receive any assistance from Medicaid. Many who are covered spend-down as a result of large medical bills. Without Medicaid coverage, the near-poor must pay Medicare premiums as well as purchase private insurance if they want help with Medicare cost-sharing. These premium payments alone can leave them economically strapped.

Lack of Supplemental Coverage—The 6.5 million elderly people who rely solely on Medicare for assistance with medical bills are particularly at-risk for impoverishment should they incur large medical bills. Poor and near-poor elderly people are the most likely to be without either Medicaid or private insurance to supplement Medicare. Thirty-four percent of poor and 28 percent of near-poor elderly people rely solely

on Medicare for assistance with their medical bills. For them, Medicare premiums and cost-sharing and payments for uncovered services are all out-of-pocket expenditures. Among elderly people who have only Medicare coverage, almost 60 percent are poor or near-poor.

In sum, poor and near-poor elderly people often face large medical bills without the assurance that either Medicaid or privately purchased supplemental insurance policies will help fill Medicare's gaps. Although it is not surprising that poor and near-poor elderly people do not purchase private supplementary coverage at rates comparable to higher income elderly people, the limited assistance provided by Medicaid is disturbing because Medicaid is intended to assist low-income elderly people.

Utilization of Health Services

Lack of supplementary coverage to fill in gaps in Medicare coverage influences access to health care services by elderly people. Although Medicare coverage is universal, ability to pay for Medicare's cost-sharing requirements varies for elderly people at different income levels. When utilization of ambulatory care services is examined after controlling for socioeconomic and health status differences, those relying solely on Medicare for coverage use fewer health services than those with supplementary coverage from either Medicaid or private insurance (Table 10).

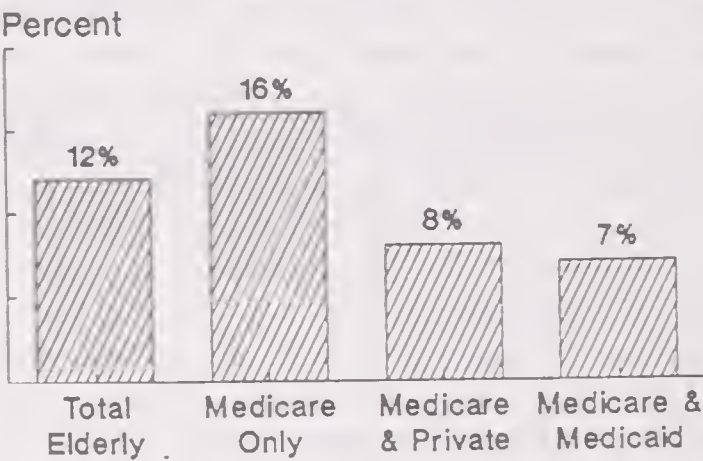
Table 10 Use of Physician Services and Prescription Drugs by the Elderly Population by Insurance Coverage, 1987

| | Total | Medicare Only | Medicare & Private | Medicare & Medicaid |
|---|-------|---------------|--------------------|---------------------|
| PHYSICIAN VISITS * | | | | |
| Percent With No Physician Visits | 12% | 16% | 8% | 7% |
| Number of Visits per User..... | 8.3 | 6.3 | 8.4 | 8.4 |
| Number of Visits per Enrollee..... | 7.3 | 5.3 | 7.8 | 7.8 |
| PRESCRIPTION DRUG USE * | | | | |
| Number of Prescriptions per User..... | 17.9 | 15.1 | 18.8 | 19.4 |
| Number of Prescriptions per Enrollee..... | 14.7 | 12.0 | 16.6 | 16.8 |

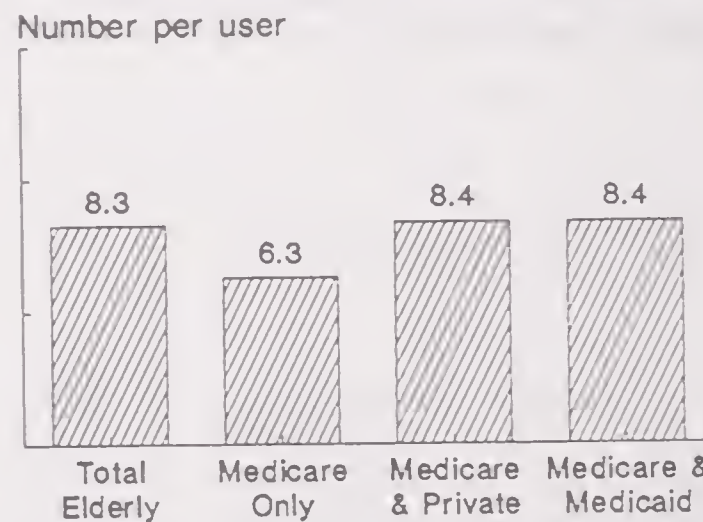
* Predicted utilization adjusted for socioeconomic and health characteristics.
SOURCE: Congressional Budget Office, 1989 based on analysis of the 1987 National Medical Expenditure Survey.

Figure 8 Utilization of Physician Services * by the Elderly Population by Insurance Coverage, 1987

Percent of Elderly with No Physician Visits in Past Year



Annual Physician Visits



*adjusted for socioeconomic characteristics and health status

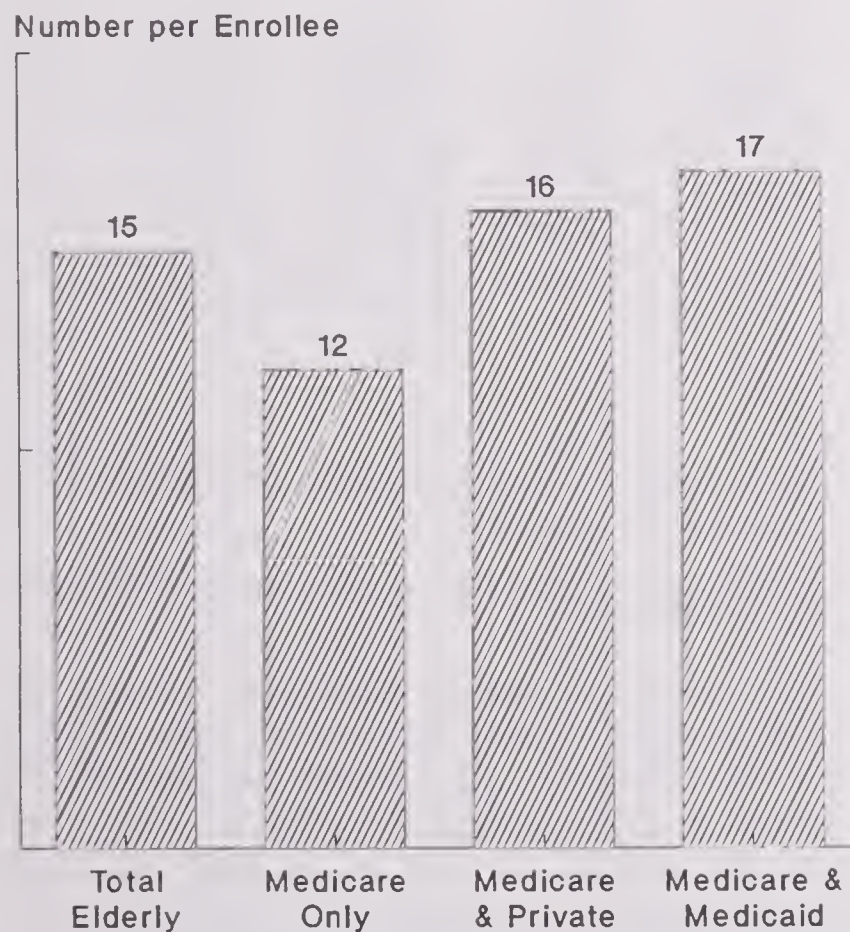
SOURCE: Congressional Budget Office, 1989 based on analysis of the 1987 National Medical Expenditure Survey.

Elderly people with Medicare-only coverage are twice as likely to have no physician visits during a year as those with supplemental coverage. Sixteen percent of elderly people with Medicare only report no physician visits in contrast to eight percent of those with private insurance and seven percent of those with Medicaid (Figure 8). Among those who use physician services, adequacy of financial protection through coverage to supplement Medicare again plays a significant role. After adjusting for health status, the elderly users of physician care with Medicare-only coverage average 6.3 physician visits per

year compared to 8.4 visits for those with Medicaid coverage or private insurance to supplement Medicare.

Access for physician services has spillover effects on utilization of other health care services. Physicians prescribe medications for their patients and Medicare beneficiaries, especially those in fair or poor health, are heavy users of prescription drugs (Moeller and Mathiowetz, 1989). It is therefore not surprising that the lower levels of physician care for those with Medicare-only coverage are also associated with reduced levels of prescription drug use. The Medicare-only population averages 12 prescriptions per year compared to 16 for the privately insured population and 17 prescriptions for the Medicaid population (Figure 9). Since Medicare does not cover prescription drugs, but Medicaid and some private insurance plans do, the combined influence of economic cost and physician access undoubtedly contributes to the lower use levels by the Medicare-only population.

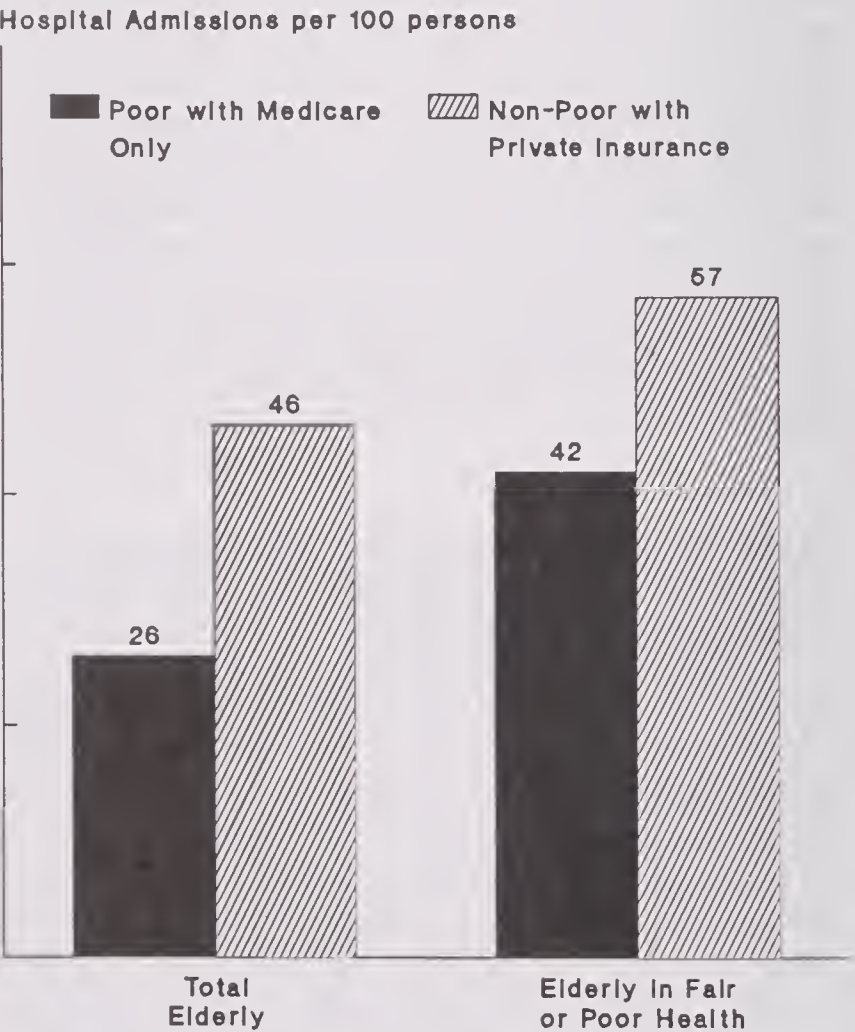
Figure 9 Utilization of Prescription Drugs * by the Elderly Population by Insurance Coverage, 1987



*adjusted for socioeconomic characteristics and health status
SOURCE: Congressional Budget Office, 1989 based on analysis of the 1987 National Medical Expenditure Survey.

Similarly, the hospitalization rates for the elderly appear to have both economic and physician access implications. The poor without coverage to supplement Medicare have 26 hospitalizations per 100 people compared to 46 hospitalizations per 100 for the privately insured non-poor population (Figure 10). Although the poor who report their health as fair or poor fare better, they still lag behind those with better insurance coverage. After adjusting for health status, the poor population with Medicare-only coverage has a hospitalization rate of 42 hospitalizations per 100 people compared to 57 hospitalizations per 100 non-poor elderly people. Despite poor health status, elderly people with incomes at or below poverty who are at risk for full payment of Medicare's hospital deductible and cost-sharing burdens appear to receive less care than their more affluent and better insured counterparts.

Figure 10 Hospitalization Rates for Selected Groups of Elderly People, 1984



SOURCE: Johns Hopkins University estimates of the non-institutionalized elderly based on the 1984 Supplement on Aging to the National Health Interview Survey.

Financial Burden for Medical Care

Medicare provides essential protection for medical care expenses for elderly Americans by financing

most hospital and physician care. Yet Medicare coverage is neither comprehensive nor free. Many acute care services, most notably prescription drugs, dental care, and vision and hearing services, are not covered by Medicare. The elderly contribute to Medicare by paying a monthly premium for physician services under Part B and paying cost-sharing and deductibles when services are used.

The financial burden associated with out-of-pocket payments for Medicare premiums and services can be substantial, especially for low-income elderly people. In 1990, the hospital deductible is \$542 per spell of illness combined with a \$75 deductible and 20 percent coinsurance on most Part B services (Figure 11). Those with extended hospital stays or multiple admissions can incur even greater liabilities (Christensen, Long, and Rodgers, 1987). Moreover, regardless of use of health services, all beneficiaries pay a premium of \$28.60 per month for Part B services, totalling \$343 for 1990.

Figure 11 Medicare Benefits and Cost-Sharing Liabilities for Hospital and Physician Services, 1990 *

| Coverage | Beneficiary Liability |
|--|----------------------------------|
| PART A | |
| Hospital Insurance for Inpatient Services | |
| Hospital deductible | \$542 per Admission |
| Coinsurance Days 61-90 | \$148 per Day |
| Coinsurance for 60 | \$296 per Day |
| Lifetime Reserve Days | |
| PART B | |
| Supplementary Medical Insurance for Physician and Related Services | |
| Premium (\$28.60 per month) | \$343 per Year |
| Deductible | \$75 per Year |
| Coinsurance | 20% of Medicare Allowable Charge |

* Effective January 1, 1990.

SOURCE: U.S. Congress, Ways and Means Committee, 1989.

Medicare liabilities for the Part A and B deductibles and Part B cost-sharing average \$491 for institutionalized and non-institutionalized Medicare enrollees (Table 11). The annual cost for Medicare services rises to \$834 when the Part B premium payment is included. These Medicare premiums and liabilities constitute five percent of the mean income of

\$17,000 of elderly Medicare enrollees. The burden, however, falls heaviest on those with low incomes and represents 18 percent of the mean income for poor and ten percent for near poor Medicare beneficiaries in contrast to four percent of mean income for non-poor beneficiaries. Yet, Medicare liabilities alone understate the true financial burden for medical care for elderly people because the cost of uncovered services and premiums for private insurance are not included.

Table 11 Cost-Sharing Liabilities for Elderly Medicare Enrollees * Resulting From the Use of Medicare Services, 1990

| | Total Elderly | Poor (less than 100% poverty) | Near-Poor (100-199% poverty) | Non-Poor (more than 200% poverty) |
|--|---------------|-------------------------------|------------------------------|-----------------------------------|
| Total Medicare Liability | \$834 | \$836 | \$854 | \$824 |
| Medicare Cost-Sharing | \$491 | \$493 | \$511 | \$481 |
| Hospital | \$170 | \$175 | \$189 | \$161 |
| Physician | \$321 | \$318 | \$322 | \$320 |
| Annual Medicare Part B Premium ** | \$343 | \$343 | \$343 | \$343 |
| Mean Income | \$17,170 | \$4,709 | \$8,893 | \$22,592 |
| Medicare Liability as a Percent of Mean Income | 5% | 18% | 10% | 4% |

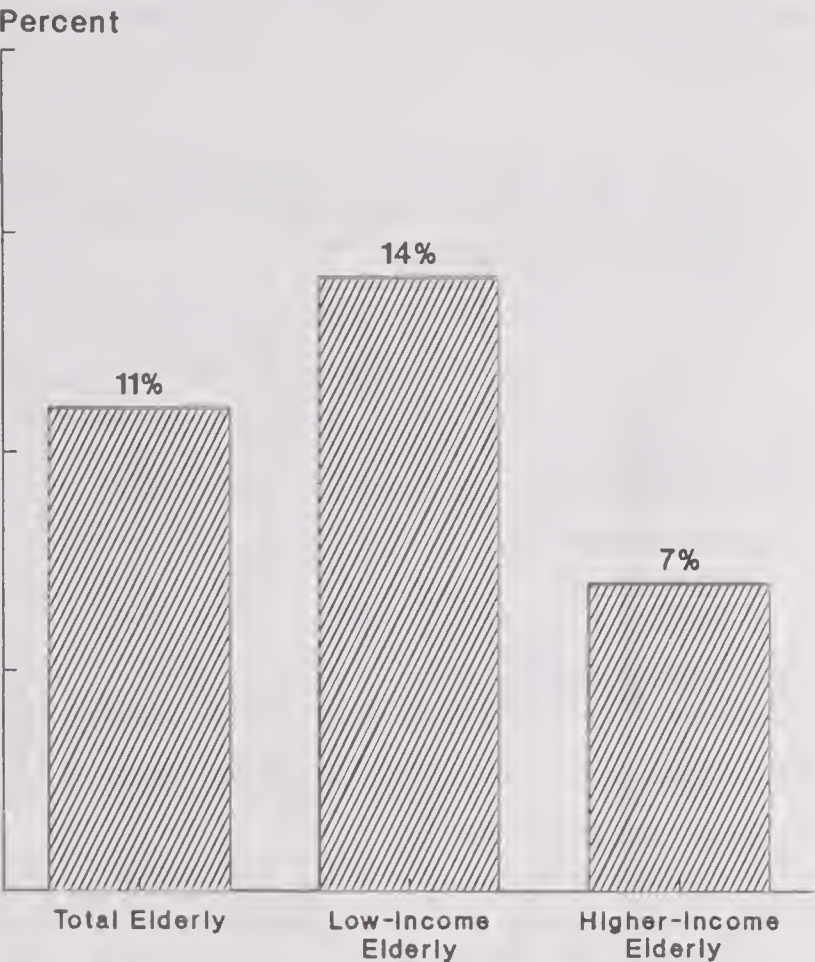
* Includes both institutional and community-based elderly Medicare enrollees.
** Premium effective as of January 1, 1990.
SOURCE: Christensen, S., 1989.

Out-of-Pocket Spending and Income—On average, elderly people living in the community spend 11 percent of their per capita incomes on out-of-pocket payments for Medicare cost-sharing, uncovered services, and premium payments (Figure 12). These expenses consume a greater portion of the income of low-income people than of higher income individuals (Feder, Moon, and Scanlon, 1987b). The poor and near-poor with per capita incomes of less than \$10,000 spent an average of 14 percent of income on medically-related expenses compared to seven percent of income for the non-poor elderly population with incomes above \$10,000.

The components of out-of-pocket medical spending by the elderly population reveal the substantial share of spending attributable to premium payments (Figure 13). Over half of all out-of-pocket costs of elderly people are for premiums. The Medicare Part B premium accounts for 16 percent of total spending and payments for private supplementary coverage constitute 40 percent of total spending. Prescription drugs account for 12 percent of spending (Table 12). An examination of out-of-pocket spending by income shows

that drugs are a higher share of out-of-pocket spending for lower income elderly people than those more economically advantaged.

Figure 12 Out-of-Pocket Expenses for Medical Care as a Percent of Per Capita Income, 1986



Note: Low Income = \$10,000 or less; Higher Income = More than \$10,000

SOURCE: Feder, Moon, and Scanlon, 1987 based on analysis of the 1980 National Medical Care Utilization and Expenditure Survey.

The difference in spending between lower and higher income people is not due to a heavier premium burden for low-income people. Excluding the Medicare Part B premium and the out-of-pocket payments for private health insurance premiums reduces overall spending for health care to four percent of income, but the poor continue to spend a higher proportion (12 percent of income) than other elderly people on cost-sharing and uncovered services (Kovar, 1986).

Poor and near-poor elderly people with incomes below \$10,000 are more likely to have catastrophic levels of out-of-pocket spending than other elderly people (Feder, Moon, and Scanlon, 1987a). Catastrophic expenses are generally defined as expenditures at or above 15 percent of income. Using this definition, 37 percent of low-income elderly individuals in contrast to six percent of higher income individuals have catastrophic expenses (Figure 14). The need for hospital care substantially increases the likeli-

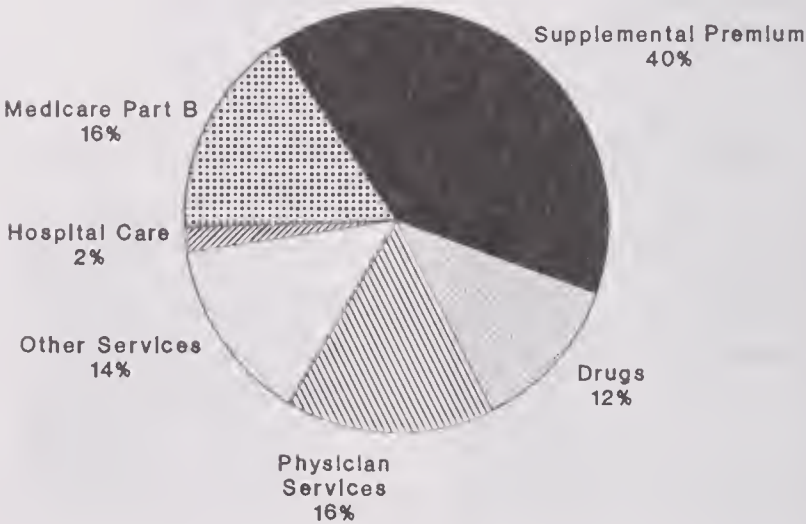
hood of catastrophic spending. Over half (56 percent) of low-income individuals with a hospital stay had catastrophic costs compared to 32 percent of low-income individuals without a hospital stay.

Table 12 Out-of-Pocket Spending for Medical Care by the Elderly Population, 1989

| | Total Elderly | Poor (less than 100% poverty) | Near-Poor (100-150% poverty) | Non-Poor (more than 150% poverty) |
|--|---------------|-------------------------------|------------------------------|-----------------------------------|
| Total Elderly | \$1,237 | \$755 | \$1,004 | \$1,391 |
| Premiums * | \$699 | \$376 | \$517 | \$809 |
| Cost-Sharing and Non-Covered Services..... | \$393 | \$265 | \$330 | \$435 |
| Drugs..... | \$145 | \$114 | \$157 | \$148 |
| PERCENT DISTRIBUTION | | | | |
| Total Elderly | 100% | 100% | 100% | 100% |
| Premiums * | 56% | 50% | 51% | 58% |
| Cost-Sharing and Non-Covered Services..... | 32% | 35% | 33% | 31% |
| Drugs..... | 12% | 15% | 16% | 11% |

* Indicates premiums for Medicare Part B and private supplemental insurance. SOURCE: Johns Hopkins University estimates based on Georgetown Policy Associates, 1987 analysis of the 1980 National Medical Care Utilization and Expenditure Survey.

Figure 13 Components of Out-of-Pocket Spending for Medical Care, 1989



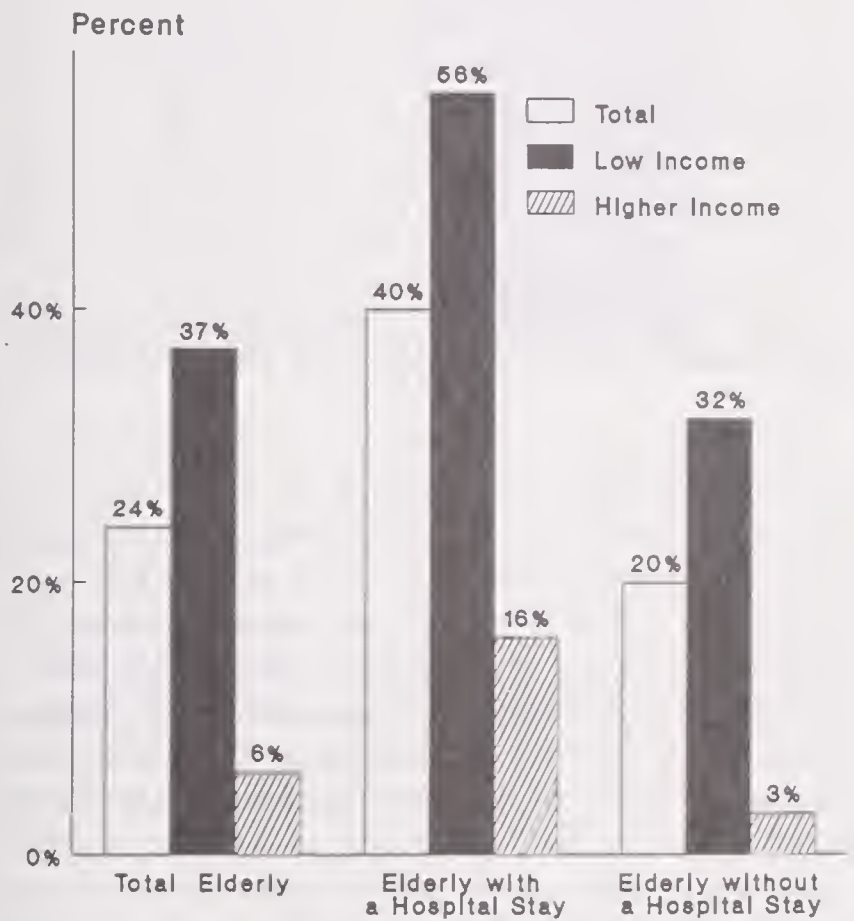
Total = \$1,237 per elderly person

SOURCE: Johns Hopkins University based on Georgetown Policy Associates analysis of the 1980 National Medical Care Utilization and Expenditure Survey.

Role of Insurance: Medicaid and Medigap—Medicaid and private supplementary insurance are essential complements to Medicare coverage for those with serious illness and the need for hospitalization. Low-income elderly people with a hospital stay who are only covered by Medicare spend 23 percent of their

income on medical expenses compared to 20 percent for those with private insurance and 14 percent for those with Medicaid (Figure 15). However, for the healthier low-income elderly without the need for hospital care, private insurance is not a good use of limited resources. For low-income people without a hospitalization, out-of-pocket spending including private insurance premiums accounts for 17 percent of income in contrast to nine percent for those with Medicare only and seven percent for those with Medicaid.

Figure 14 Percent of Elderly People With Out-of-Pocket Spending for Acute Care Exceeding 15 Percent of Income, 1986



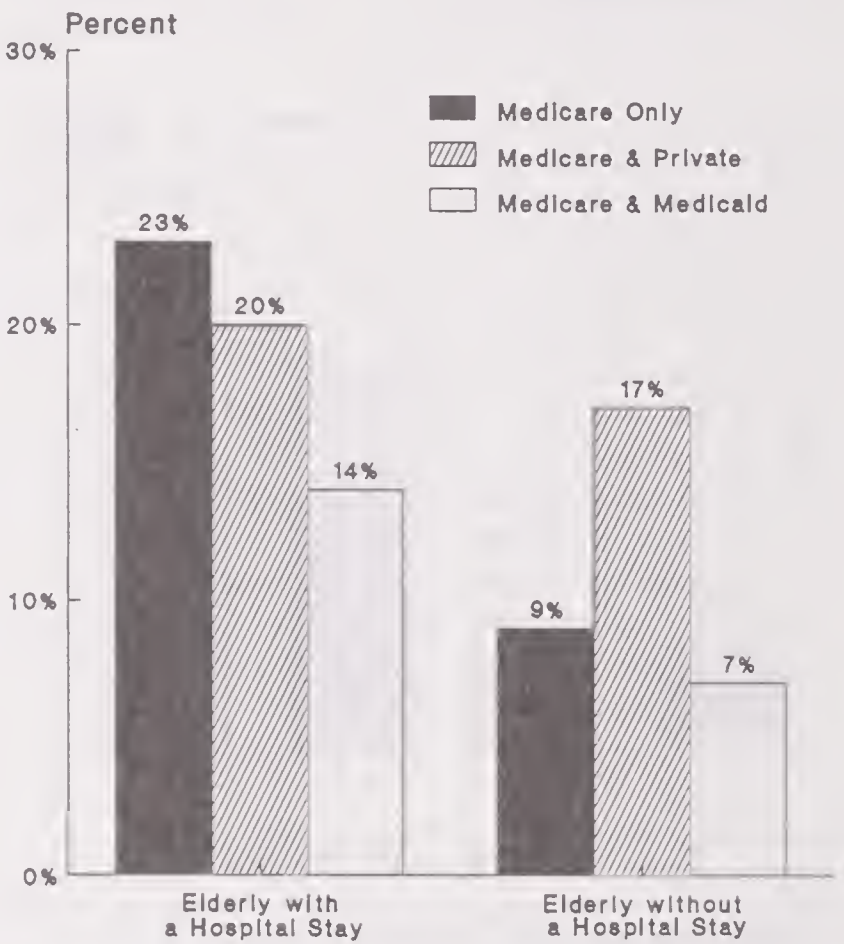
Note: Low Income = \$10,000 or less;
Higher Income = More than \$10,000

SOURCE: Feder, Moon, and Scanlon, 1987 based on analysis of the 1980 National Medical Care Utilization and Expenditure Survey.

Medicaid clearly helps to reduce financial burdens for those who are covered. The poor elderly population covered by Medicaid had out-of-pocket expenses of \$287 per year in 1989 in contrast to expenses exceeding \$1,000 for the poor and near-poor without Medicaid coverage (Figure 16). Poor elderly people without Medicaid coverage paid twice as much for prescription drugs and four times more for cost-sharing and uncovered services than the poor with Medicaid (Table 13). Medicaid coverage of prescription drugs helps reduce the economic barriers that impede

utilization for the low-income elderly. Annual prescription drug expenditures for those with Medicaid are a third higher than expenditures for those without drug coverage (Mathiowetz, 1990).

Figure 15 Out-of-Pocket Spending as a Percent of Income for Low-Income * Elderly People by Hospital Use and Insurance Coverage, 1986



*Income of \$10,000 or less

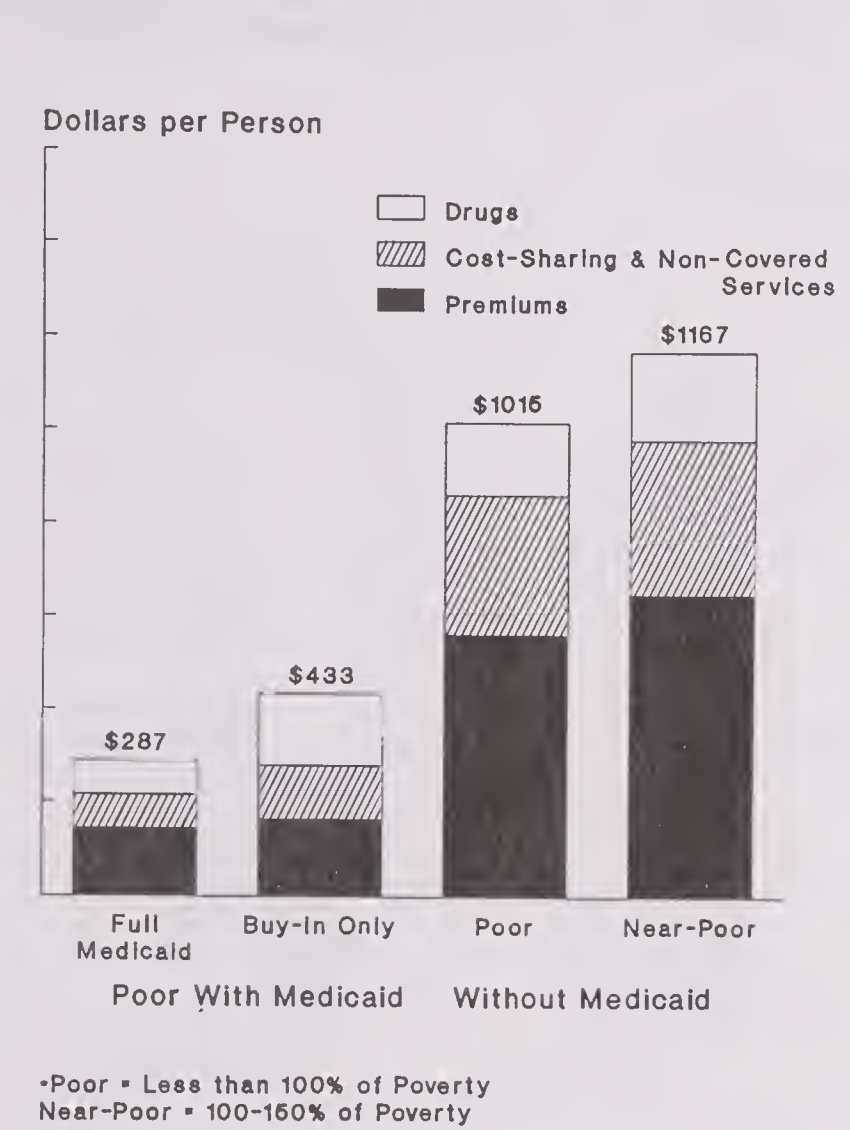
SOURCE: Feder, Moon, and Scanlon, 1987 based on analysis of the 1980 National Medical Care Utilization and Expenditure Survey.

The greatest savings for those fortunate enough to have Medicaid coverage come from reduced premium payments. Those without Medicaid coverage pay more out-of-pocket in premium costs than their Medicaid covered counterparts pay in total. The elderly poor who have buy-in coverage but are not entitled to full Medicaid benefits pay more out-of-pocket (\$433), but are still better off than those who are Medicare only or privately insured.

For many near-poor elderly people medical expenses can reduce their meager incomes to levels that in effect shift them into poverty. A single elderly person with an income of \$7,500 is technically not poor. However, if that individual had out-of-pocket expenses for cost-sharing and prescription drugs that exceeded \$1,500, those expenses would reduce the income available for daily living expenses to below

the poverty level. In this way, many non-poor elderly people can actually become impoverished by their medical expenses.

Figure 16 The Impact of Medicaid on Out-of-Pocket Spending for Medical Care by Low-Income * Elderly People, 1989



SOURCE: Johns Hopkins University estimates based on Georgetown Policy Associates analysis of the 1980 National Care Utilization and Expenditure Survey.

Many near-poor elderly people are, in fact, the hidden poor. One-third of near-poor elderly people are reduced to poverty by their out-of-pocket payments for medical care. Elderly people in higher income groups also suffer a reduced standard of living (Table 14). If poverty rates were calculated after deducting medical expenses from available income, the percent of elderly people who are living in poverty would increase from 12 percent to 17 percent (Figure 17).

Premium payments to assure protection against unexpected or large medical expenses are a major contributor to the expenses impoverishing many elderly people. Medicare premiums and out-of-pocket payments to purchase private Medigap coverage accounts for 40 percent of the out-of-pocket spending by the medically impoverished (Commonwealth Fund Commission, 1987). However, without Medicare Part

B or Medigap, serious illness can bring financial devastation.

Table 13 The Impact of Medicaid on Out-of-Pocket Spending for Medical Care by Low-Income Elderly People, 1989

| | Poor With Medicaid | | Without Medicaid | |
|--|--------------------|-------------|------------------|-----------|
| | Full Medicaid | Buy-In Only | Poor | Near-Poor |
| Total Elderly | \$287 | \$433 | \$1,015 | \$1,167 |
| Premiums * | \$145 | \$165 | \$562 | \$650 |
| Cost-Sharing and Non-Covered Services..... | \$71 | \$114 | \$299 | \$328 |
| Drugs..... | \$71 | \$154 | \$154 | \$189 |
| PERCENT DISTRIBUTION | | | | |
| Total Elderly | 100% | 100% | 100% | 100% |
| Premiums * | 50% | 38% | 55% | 56% |
| Cost-Sharing and Non-Covered Services..... | 25% | 26% | 30% | 28% |
| Drugs..... | 25% | 36% | 15% | 16% |

Note:
Poor = Less than 100% poverty
Near-Poor = 100-150% poverty
* Indicates premiums for Medicare Part B and private supplemental insurance.
SOURCE: Johns Hopkins University estimates based on Georgetown Policy Associates, 1987 analysis of the 1980 National Medical Care Utilization and Expenditure Survey.

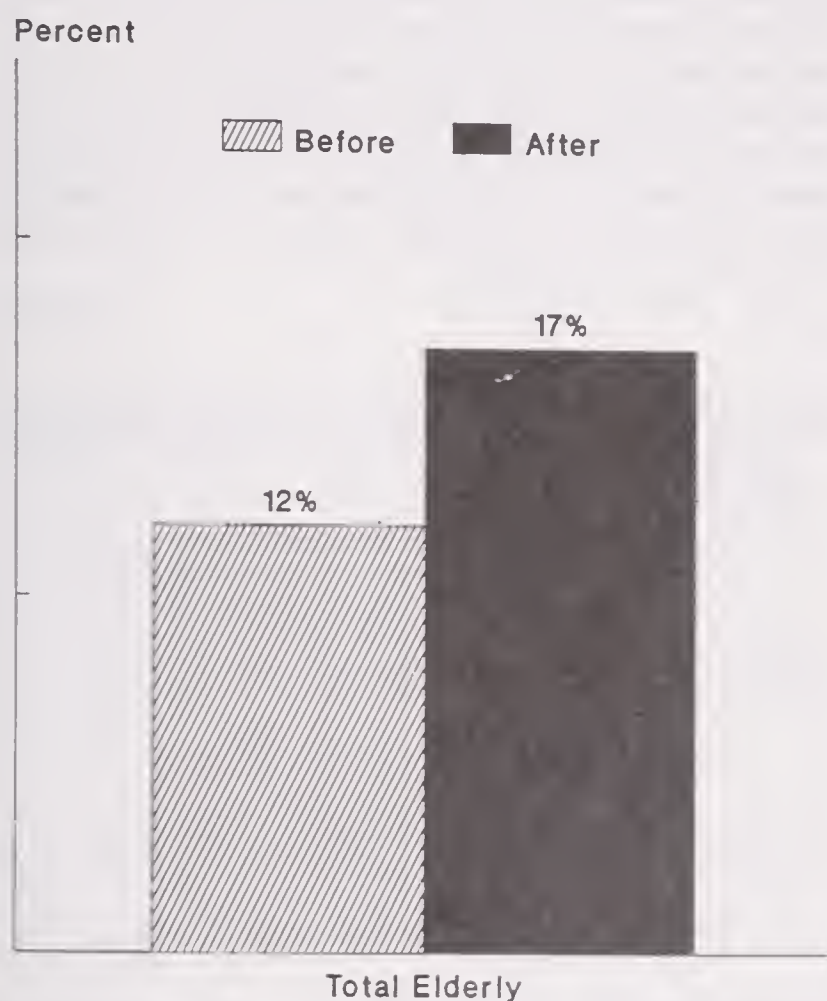
Expanding Medicaid coverage to more poor and near-poor elderly people would assist in moderating out-of-pocket expenditures for medical care and premiums and could help prevent impoverishment of many older people. Poor elderly people with Medicaid coverage have the most comprehensive protection while those with only coverage from Medicare are the most at risk of financial devastation from illness.

Table 14 Shifts in Poverty Status Due to Medical Expenses

| Poverty Status Before Medical Expenses | Poor (less than 100% poverty) | Near-Poor (100-149% poverty) | Modest (150-299% poverty) | Moderate to High (more than 300% poverty) |
|---|-------------------------------|------------------------------|---------------------------|---|
| Poor (less than 100% poverty) | 100.0 | | | |
| Near-Poor (100-149% poverty) | 32.3 | 67.7 | | |
| Modest (150-299% poverty)..... | 0.3 | 15.3 | 84.4 | |
| Moderate to High (300% poverty or more) | | | 12.3 | 87.7 |

SOURCE: Estimates prepared by Georgetown Policy Associates based on 1980 National Medical Care Utilization and Expenditure Survey.

Figure 17 Poverty Among Elderly People Before and After Medical Expenses



SOURCE: Commonwealth Fund Commission on Elderly People Living Alone, 1987.

Plan for Reform

The greater financial burdens of low-income people in comparison to the more affluent elderly population mean that access to care and use of appropriate medical care can be placed in jeopardy by financial considerations. The lower utilization levels of the elderly population relying solely on Medicare coverage demonstrates the importance of adequate supplementary insurance to alleviate the financial burdens for Medicare cost-sharing and, in some cases, assist with payment for uncovered services, such as prescription drugs.

Medicaid coverage to supplement Medicare is a highly targeted approach to improve access to medical care, ease financial burdens, and eliminate the need for poor and near-poor individuals to pay premiums for private insurance. Use of medical services by those with Medicaid coverage is comparable to utilization levels by those with private insurance and significantly higher than that of the Medicare-only population.

Medicaid coverage has also been shown to ease financial burdens significantly. Poor elderly people with Medicaid coverage spend less than \$300 per year out-of-pocket compared to over \$1,000 per year for the uncovered poor and near-poor elderly population. Much of the difference in out-of-pocket spending is due to premium payments and out-of-pocket spending for drugs by those without Medicaid. Payment of Medicare premiums and elimination of the need to purchase private coverage is, in fact, Medicaid's greatest contribution to easing financial burdens for medical care among the low-income population.

Medicaid currently operates as the safety-net Medigap plan for two million poor and near-poor Medicare beneficiaries, but Medicaid's reach is limited. Nearly 10 million low-income elderly people are not assisted by Medicaid and are left on their own to pay Medicare and insurance premiums and cover cost-sharing. When the Medicare Catastrophic Coverage Act is fully implemented in 1992, states will be required to pay the Medicare premium and cost-sharing requirements for all beneficiaries with incomes below the poverty level. However, some poor elderly people will not qualify because their assets exceed the permissible level of \$4,000 for Medicaid eligibility and the provision does not extend to the near-poor elderly population.

The scope of Medicaid protection should be broadened to pay Medicare premiums and cost-sharing and cover prescription drugs for all low-income elderly people with incomes below 200 percent of the Federal poverty level (roughly 12,000 in 1989). On a per capita basis, the average cost of these benefits is estimated at about \$1,250 in 1990 including \$343 for the Medicare Part B premium, \$500 for cost-sharing under Part A and B, and \$425 for the prescription drug benefit.

For the 3.5 million elderly people living on incomes below the poverty level, Medicaid would cover the full cost of these benefits without cost-sharing. The 8.2 million near-poor elderly people with incomes between 100 and 200 percent of the poverty level would receive comparable assistance from Medicaid, but would contribute to premium and cost-sharing obligations and prescription drug costs on a sliding scale. Those with incomes from 100–149 percent of poverty would pay 25 percent of the cost and those with incomes from 150 to 200 percent of poverty would contribute 50 percent.

Eligibility for Medicaid assistance would be determined solely on the basis of income, without regard to asset levels. Currently, individuals with assets in

excess of \$4,000 and couples with assets above \$6,000 are generally ineligible for Medicaid coverage. Eliminating the asset test will simplify the eligibility process and remove some of the welfare stigma of Medicaid. It should help increase participation in Medicaid by low-income elderly people.

This proposal would expand coverage to 9.9 million low-income elderly people currently without Medicaid coverage (Table 15). Improved protection would be provided to 2.5 million poor elderly people. Although many of these people became eligible for buy-in assistance as a result of the Medicare Catastrophic Coverage Act, this proposal would expand Medicaid protection to also include coverage of prescription drugs. In addition, those previously excluded from buy-in assistance under MCCA as a result of the asset restrictions would now be eligible for Medicaid coverage. The largest group of beneficiaries are the 7.4 million near-poor elderly people who would be newly eligible for assistance with Medicare premiums and cost-sharing and coverage of prescription drugs under the Medicaid program.

The cost of this proposal is estimated to be \$2.4 billion in additional Federal revenues in 1990 (Table 16). State matching expenditures are estimated at \$2.0 billion, for a total cost of \$4.4 billion in 1990. Within this plan, one-third of expenditures would be for improved protection of the poor elderly and the remainder would be directed toward expanding coverage to the near-poor elderly population. As a result, Medicaid buy-in assistance and prescription drug coverage would be available to supplement Medicare for all 11.7 million low-income elderly Americans.

Table 15 Number of New Eligibles Assisted by Proposal to Expand Medicaid Coverage of the Low-Income Elderly Population, 1990

| | Number of Elderly People (millions) | | |
|---|-------------------------------------|--------------------------------|------------------------|
| | Total | Current Medicaid Beneficiaries | New Medicaid Eligibles |
| Total Low-Income Elderly Population | 11.7 | 1.8 | 9.9 |
| Poor Elderly People (less than 100% poverty)..... | 3.5 | 1.0 | 2.5 |
| Near-Poor Elderly People (100-200% poverty)..... | 8.2 | 0.8 | 7.4 |

Note: New Medicaid eligibles includes those who were excluded from expansions of buy-in assistance under the MCCA due to asset restrictions.
SOURCE: Johns Hopkins University estimates based on CBO analysis of the Current Population Survey, March 1989.

These cost estimates are based on participation rates of 100 percent for the poor elderly who would be eli-

gible to receive a fully subsidized benefit package and 50 percent for the near-poor who would be required to make a sliding scale contribution based on income. Program experience has generally shown lower rates of participation for Medicaid largely due to lack of awareness about the program and potential eligibility, and difficulty in completing the eligibility process. As a result, Medicaid expansions must be accompanied by simplification of the eligibility process and community-level outreach programs if they are to reach their intended target populations.

Table 16 Cost of Proposal to Expand Medicaid Coverage of the Low-Income Elderly Population, 1990

| | Cost (billions of dollars) | | |
|---|----------------------------|---------|-------|
| | Total | Federal | State |
| Total Low-Income Elderly Population | \$4.4 | \$2.4 | \$2.0 |
| Buy-In Assistance | \$2.2 | \$1.2 | \$1.0 |
| Prescription Drugs..... | \$2.2 | \$1.2 | \$1.0 |
| Poor Elderly People (less than 100% poverty)..... | \$1.4 | \$0.8 | \$0.6 |
| Buy-In Assistance | \$0.2 | \$0.1 | \$0.1 |
| Prescription Drugs..... | \$1.2 | \$0.7 | \$0.5 |
| Near-Poor Elderly People (100-200% poverty)..... | \$3.0 | \$1.7 | \$1.3 |
| Buy-In Assistance | \$2.0 | \$1.1 | \$0.9 |
| Prescription Drugs..... | \$1.0 | \$0.6 | \$0.4 |

Note: Buy-in assistance includes the Medicare Part B premium and cost-sharing for hospital and physician services. On a per capita basis, the cost of the total benefit package, including prescription drugs, is estimated to be about \$1,250.
Cost estimates assume a full year of implementation and a participation rate of 100 percent for poor elderly who would be eligible to receive a fully subsidized benefit package and 50 percent for the near-poor elderly who would be required to make a sliding scale contribution based on income. Those with incomes between 100 and 149 percent of poverty would contribute 25 percent of the total benefit cost and those with incomes between 150 and 200 percent of poverty would contribute 50 percent.
SOURCE: Author's estimates based on Christensen, S., "Estimates for Aged Medicare Enrollees, 1990."

Improving Medicaid's assistance to low-income elderly people builds on the Medicare Catastrophic Coverage Act's expansion of buy-in protection to Medicare beneficiaries with incomes below poverty, but broadens the scope of protection to include prescription drugs and offer assistance to the near-poor population. The administrative structure for eligibility determination and payment of premiums and cost-sharing is already in place in most states and can be used as the foundation for expanded coverage. With buy-in coverage plus prescription drug coverage, Medicaid will provide substantial relief from the premiums and out-of-pocket financial burdens now faced by low-income Medicare beneficiaries. In addition, states should also be encouraged to expand coverage to other services generally provided by Medicaid, such as dental care and vision and hearing services,

by making federal matching funds available to states that elect to offer more comprehensive coverage.

Expanding Medicaid assistance for the low-income elderly population is an incremental reform that would provide immediate relief from medical burdens to the most vulnerable of the elderly population. Extension of Medicaid's safety net is essential to assure needed medical services will no longer impose an un-

manageable financial burden for poor and near-poor elderly Medicare beneficiaries. Future initiatives may look to broadening the scope of Medicare coverage for all elderly people, but in the short run Medicaid reforms directed toward the low-income population can make a measurable difference in improving access to care and alleviating the financial burdens associated with medical care services.

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Long-Term Care

CASE MANAGEMENT IN LONG-TERM CARE *

INTRODUCTION

Case management is used in many different settings and for a variety of purposes. As a result, the term case management means different things to different people. Researchers, health care and social service professionals, policy analysts, and others who talk about case management may or may not be talking about the same thing.

In developing a national long-term care program, it is important to be as clear as possible about what case management is expected to do and how it should operate in the program, because some of the most significant outcomes of the program are likely to be determined within the case management process. As discussed in this paper, case management is likely to be the mechanism by which decisions are made about the amount and kind of services people will receive through the program. In turn, those decisions will determine the cost of the program, how people perceive it, and whether it meets their needs.

This OTA staff paper proposes a definition of case management and points out several conceptual distinctions that are important in thinking about the case management component of a national long-term care program. The paper discusses whether case managers should determine the amount and kind of services people are authorized to receive through the program and whether the case management component of the program should be split between two agencies. The paper also reviews some findings of OTA's forthcoming report, *Confused Minds, Burdened Families: Finding Help for People With Alzheimer's and Other Dementias*, that relate to questions about the agencies that might provide case management in a national long-term care program and the appropriate role of the program and the case managers who implement it with respect to the quality of the long-term care services that are provided or paid for by the program.

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Much valuable information about case management in long-term care programs is available from several sources. Case management has been a component of virtually all the long-term care research and demonstration projects that have been conducted in the United States since the mid-1970s, including the National Long-Term Care Channeling Demonstration project (25,40,47,55). Case management is a central component of many State long-term care programs, including State programs that are funded in whole or in part through Medicaid 2176 Home and Community-based Waivers (34,35). Case management is also a central component of the Social/Health Maintenance Organization (S/HMO) demonstration program (3,42). All of these programs allocate long-term care services and/or funding for such services. Research findings and practical knowledge derived from these programs are relevant to many of the difficult issues that must be resolved in designing the case management component of a national long-term care program. For the purpose of designing that component of the program, the research findings and practical knowledge derived from these programs are probably more helpful than theoretical discussions about case management or information about the role and operation of case management in other programs that do not allocate long-term care services or funding for services. It is likely that some of the case management policies and procedures developed by the former programs could be adopted directly by a national long-term care program.

WHAT IS CASE MANAGEMENT

As noted above, case management means different things to different people. In the context of long-term care for elderly and disabled people, OTA defines case management as a process that includes five functions (67):

- assessing a client's needs,
- developing a plan of care for the client,
- arranging and coordinating the needed services,

- monitoring and evaluating the services the client receives, and
- reassessing the client's situation as the need arises.

Most commentators agree that case management in long-term care includes these five functions (6,13,18,24,25,31,36,39,43,51,52,61,63,71,72), but there are still many unresolved definitional issues with respect to case management. First, some commentators include other functions—notably, case finding, screening, client education, and counseling—in their definitions of case management. Second, the implementation of each of the case management functions varies, depending on factors such as the type of the agency that provides it, the objectives and other functions of that agency, whether the agency provides services in addition to case management, the goals, educational background, experience, and training of the case manager, and the number of clients the case manager has. The same factors also influence the relative amount of emphasis the case manager and the agency place on each of the case management functions.¹

Many conceptual distinctions have been proposed to categorize the differences in the role and practice of case management in different agencies and settings (see, for example, Austin, et al., 1985 (16); Capitman, et al., 1986 (25); Kane, et al., 1989 (39); and Weil, 1985 (71). Two conceptual distinctions are particularly important in thinking about the case management component of a national long-term care program. The first of these is a conceptual distinction between case management as *an administrative process* and case management as *a clinical or helping process*. In many agencies that allocate long-term care services or funding for long-term care services, case managers perform certain tasks that are essential for the administration of those benefits in accordance with agency or program regulations. These administrative tasks include determining people's eligibility for the benefits, authorizing the benefits, and monitoring and accounting for their use. When case managers are responsible for these administrative tasks, the case management functions mentioned earlier are modified to include the tasks. For example, the function of arranging and coordinating services is modified to include administrative procedures for authorizing services and funding for services. The functions of monitoring the services and of reevaluating the client's needs are modified to include procedures to account for the services and

funds that are used and to recertify the client's eligibility for services.

In some agencies that allocate long-term care services and funding for services, case management is primarily a series of administrative tasks intended to allocate benefits in accordance with agency or program regulations. In other agencies, case management is primarily a clinical or helping process in which the case manager functions more as a professional helper, counselor, and client advocate than as an administrator of benefits. Clinical case management responds to a variety of difficult problems that confront people who need long-term care. One of those problems is that the long-term care service environment is extremely complex and fragmented in many communities, so that some people who need long-term care require assistance to locate and arrange services. A second problem is that some people who need long-term care have multiple service needs, so that they may require assistance in coordinating the services of several different providers. Lastly, some people who need long-term care require assistance in defining the problems they are facing, determining what kind of services might be helpful, and mobilizing informal (unpaid) sources of help (relatives, neighbors, friends, church groups, etc.). As professional helpers, counselors, and client advocates, case managers provide all these kinds of assistance.

If it were possible to make a clear distinction in reality between case management as an administrative process and case management as a clinical or helping process and call one case management and the other something else, it would be easier for everyone to understand and communicate clearly about case management and its role and operation in a national long-term care program. That distinction cannot be applied precisely in reality, however. As practiced in many agencies, case management includes both administrative and clinical tasks, and many case managers who administer long-term care benefits for their agencies perceive themselves as professional helpers, counselors, and advocates.² Moreover, OTA is not aware of any research that shows that as a group these case managers perform the clinical case management tasks differently than case managers who do not administer benefits.

¹ In this paper, the term "case manager" is used to refer to an individual who performs the case management functions listed above. As is true of case management, however, the term "case manager" means different things to different people, and in reality, some individuals who perform these case management functions are not called "case managers" and other individuals who are called "case managers" do not perform the functions.

² In a study by the University of Washington, 127 case managers in agencies that allocate services and funding for services in Oregon and Washington State were asked to rate the importance of 11 possible goals of case management (15). All these case managers' jobs involved administrative tasks related to allocating services and funding for services, but the goals they identified as most important had to do with helping and advocacy. In the view of these case managers, at least, the administrative and clinical aspects of case management are intertwined.

Even though the conceptual distinction between case management as an administrative process and case management as a clinical or helping process cannot be applied precisely in reality, it is useful in thinking about the role and operation of case management in a long-term care program because it underlies one of the primary areas of disagreement about case management in such program. It is in the context of performing administrative tasks related to the allocation of program benefits that case managers become the “gatekeepers” in a long-term care program, and it is in that context that they are likely to be perceived as restricting clients’ access to needed services. Some people argue that case management as an administrative “gatekeeping” process is not compatible with case management as a clinical or helping process and that the “gatekeeping” and clinical case management tasks should be performed by different agencies or different units of the same agency. Other people argue that the two types of tasks can be effectively performed by the same agency or unit. This issue is discussed further in a later section of this paper. OTA’s perception is that both the administrative and clinical tasks are performed by the same case manager in most long-term care programs that allocate services or funding for services—at least after an initial determination has been made that an individual is eligible for the program.

The second important conceptual distinction in thinking about the case management component of a national long-term care program is the distinction between a case management process that is “*service-centered*” vs. one that is “*comprehensive*.” *Service-centered case management* is case management that is provided in conjunction with the provision of a particular service (e.g., homemaker or home health aide services). *Comprehensive case management* takes place independent of the provision of any particular service (46).

The distinction between service-centered and comprehensive case management is important because it underlies two other areas of disagreement about case management in a long-term care program. Many agencies and individuals that provide services also “case manage” their clients. One area of disagreement is whether a long-term care program should provide case management for people who are receiving case management from a service provider in conjunction with a particular service (i.e. service-centered case management). The more widely debated issue is whether service providers should be the case managers for a long-term care program. Both issues are discussed later in this paper.

Some commentators make a distinction between case management and “care management,” “care co-

ordination,” “service coordination,” or similar terms. Although these distinctions may be meaningful within the conceptual framework developed by a given commentator, the terms are not used in a consistent way by different commentators. Thus, the use of these terms does not facilitate clear communication about case management, and OTA does not consider the terms helpful in thinking about the case management component of a long-term care program.

Should Case Managers Determine the Amount and Kind of Services People Receive Through a National Long-Term Care Program?

Case managers determine the amount and kind of services people receive in virtually all existing long-term care programs that allocate services or funding for services. In many of these programs, there are at least two steps that take place before the amount and kind of services a person will receive are determined. First, the person’s eligibility for the program is determined. Eligibility is usually determined on the basis of only a few factors and may or may not be determined by a case manager.³ Once the person is found to be eligible for the program, he or she usually receives an assessment by a case manager. Based on the results of the assessment, the case manager then develops a plan of care which includes a determination of the amount and type of services that will be authorized for the person. The assessment usually addresses many more factors than are considered in the eligibility determination. Factors such as the person’s mental, and emotional status, the person’s living arrangements and physical and social environment, and the availability of help from informal (unpaid) caregivers are frequently included in the assessment. All of these factors are relevant to determining the amount and kind of services a person needs but not necessarily relevant to determining eligibility for the program.

In many long-term care programs, the assessment is based on a formal assessment instrument—i.e. an interview schedule that addresses all or many of the factors just noted. If there were an assessment instrument that could accurately determine the amount and kind of services a person needs without requiring the judgment of a case manager, that instrument could be used to determine what services the long-term care program should provide for the person. Sometimes descriptions of client assessment and care planning in

³ Existing long-term care programs generally base eligibility for program benefits on categorical criteria (age, disability, etc.), medical and functional status, financial need, and/or the person’s need for nursing home care, as defined by the State’s Medicaid program regulations.

long-term care programs sound as if there are such instruments and as if the determination of the amount and kinds of services authorized for clients of the program comes directly from the assessment instrument. At present, however, there is no assessment instrument that has been shown to identify the amount or kind of services that people need. In fact, research indicates that even in long-term care programs in which there are standardized assessment procedures that include the use of an assessment instrument and the case managers are trained to follow the procedures precisely, clients who are the same in terms of the factors addressed by the assessment are perceived by different case managers as having different needs, and the amount and kind of services authorized for them by different case managers vary (1,25,58).

Some efforts are underway to standardize care planning, so that the same amount and kind of services will be authorized by case managers for people whose assessments are the same (1,58). These efforts are not complete, however, and it is not clear how soon such a "case-mix" approach to long-term care planning might be ready for use in a national long-term care program. Nor is it clear that determinations of the amount and kinds of services to be authorized for clients of a long-term care program *should* rely solely on an assessment instrument without requiring the judgment of a case manager. It is clear, as mentioned earlier, that there is currently no assessment instrument that has been shown to identify the amount or kind of long-term care services that people need.

Aside from having a case manager determine the amount and kind of services to be authorized for clients of a long-term care program, the only other alternative would be to allow people who are eligible for the program to decide what services they need (with or without the advice of a physician, other health care or social service professional, or anyone else) and then to set up a procedure by which the program would review and authorize or decline to authorize reimbursement for the services retrospectively. If this approach were implemented, people who were eligible for the program would use long-term care services and then they or the service provider would submit a claim for reimbursement, in much the same way that claims are submitted for Medicare reimbursement for home health care services. OTA is not aware of any long-term care program that operates in this way.

The main points here are: 1) that the determination of the amount and kind of services to be authorized for a person through a long-term care program is different from the determination that the person meets the eligibility requirements for the program, and 2)

that there appears to be no viable alternative to having a case manager determine the amount and kind of services to be authorized for people through a national long-term care program.⁴ These points raise certain problems for such a program. The first problem is the predictably negative response of people who are found to be eligible for the program and then discover that, in fact, a case manager will determine the amount and type of services they will be authorized to receive through the program. This problem is likely to be particularly acute if the long-term care program is an entitlement program.

Another problem is that the administrative "gatekeeping" tasks in case management clearly arise in the context of assessment and care planning, not just eligibility determination. Therefore, if policy makers want to separate the administrative "gatekeeping" tasks from the clinical tasks in the case management component of the long-term care program in order to address the alleged incompatibility of the two types of tasks, it will be necessary to place the responsibility for assessment and care planning in one agency or unit of an agency and the responsibility for the clinical case management tasks in another agency or another unit of the same agency.

Some recent proposals for a national long-term care program place the responsibility for determining eligibility in one agency or one unit of an agency and the responsibility for assessment, care planning, and other case management functions in another agency or another unit of the same agency. The rationale that is sometimes given for this approach is to separate the "gatekeeping" and clinical case management tasks. Clearly, this rationale is based on a misunderstanding of the process by which decisions are made about the amount and kind of services that will be authorized through the program.

Another possible approach is to place the responsibility for eligibility determination, assessment, and care planning in one agency or one unit of an agency and the responsibility for clinical case management tasks in another agency or unit. Since people's service needs change over time, assessment and care planning must be ongoing. If this second approach were implemented, each client would have to have two case managers, one to administer the program benefits and one to perform clinical case management tasks. Although this approach might create an adversarial relationship between the two case managers, some people

⁴ Although there appears to be no viable alternative to having a case manager determine the amount and kind of services to be authorized for people through a long-term care program, many structural and operational aspects of the program will affect how the case manager performs this function. Some of these structural and operational aspects are discussed later in this paper.

believe that it is the only way to guarantee that clients of a long-term care system have an advocate in the program. The approach would be likely to be duplicative and therefore expensive.

A third possible approach is to have the original determination of eligibility, the initial assessment, and the initial care plan done by one agency or unit of an agency and then to have ongoing case management provided by another agency or unit of an agency. This approach does not effectively separate the “gatekeeper” and clinical case management tasks, because the ongoing case management would still include both “gatekeeper” tasks (i.e., reassessments and redeterminations of the amount and kind of services to be authorized for a client) and clinical case management tasks.

The fourth possible approach, and the one that is in effect in most existing programs that allocate long-term care services and/or funding for services, is to assign responsibility for both ongoing administrative case management tasks and clinical case management tasks to the same agency and case manager. This is the approach that raises concerns about the incompatibility of administrative “gatekeeping” tasks and clinical tasks. If this approach were adopted for a national long-term care program, safeguards would have to be built into the program to try to ensure that case managers’ determinations of the amount and kind of services to be authorized for clients would be fair and that case managers would perform clinical tasks for their clients to the greatest extent possible. Such safeguards could include training for case managers about how to balance the conflicting demands of the “gatekeeper” and clinical/advocacy roles, the provision of forums for consultation and supervision for case managers who confront difficult decisions about the amount and kind of services to be authorized for a client, and an effective appeals process. Some people would argue that these safeguards are not adequate to ensure that people have an advocate in the program.

Each of the 4 approaches discussed above has drawbacks. The important point is that there is no simple way to separate the “gatekeeping” and clinical case management tasks and that placing the responsibility for these tasks in different agencies or different units of the same agency may create more problems than it solves with respect to balancing the administrative “gatekeeping” tasks and the clinical tasks of case management.⁵

⁵ A different reason for placing various case management functions in more than one agency is to create an oversight mechanism by which one agency would review decisions about services made by the other agency. Policy makers might decide that such an oversight mechanism is necessary if, for example, the Federal government were paying for long-term care services that were being authorized by State-administered agencies, and the Federal

Who Should Receive Case Management in a Long-Term Care Program?

As discussed in the previous section, decisions about the amount and kind of services people receive through a long-term care program probably must be made by case managers. Thus everyone who receives services through the program must receive case management in the sense of the administrative tasks that are essential to allocate services and funding for services in accordance with program regulations.

Whether everyone who receives services through the program should receive case management beyond those essential administrative tasks is another question. As discussed earlier, at least some people who need long-term care services also require assistance with defining their service needs, locating and arranging services, and coordinating the services of multiple providers. Anecdotal evidence suggests that many people who need long-term care require these kinds of assistance.

The findings of an exploratory study conducted for OTA in Pennsylvania and of market surveys conducted for the Robert Wood Johnson Foundation’s Supportive Services Program for Older Persons indicate, however, that some people do not want case management. The study conducted for OTA involved interviews with 46 family caregivers of people with dementia (73). Some of the caregivers did not want and did not think they needed case management. One-fourth of the caregivers said they would rather arrange services themselves than have a case manager act as an intermediary. The caregivers’ major concern about case management was control: they wanted to retain control over the kinds of services to be provided for their relative with dementia and over who would provide the services.

The findings of market surveys conducted for the Robert Wood Johnson Foundation’s Supportive Services Program for Older Persons also suggest that many older people and their families do not want case management and that they do not understand why they might need it (33). Older people and their families who responded to the market surveys indicated that they did not see themselves as “cases” to be managed and that they did not understand why they would need a special person or a special set of functions in order to obtain services. Many of them expressed confidence in their ability to define their own

government wanted to review the service allocation decisions made by the State-administered agencies. Creating such an oversight mechanism would not necessarily resolve concerns about the incompatibility of “gatekeeping” and advocacy-related tasks in case management, however. In fact, these concerns would be relevant to decisions made by both agencies.

service needs and did not think they would need a case manager to help with that (21). Ninety-five percent of the older people and 86 percent of the caregivers said they had no need for care planning (23).

These findings do not prove that the people who were interviewed do not need case management or would not need it at some time in the future. The findings only suggest that some people do not want case management. Policy makers could conclude that a case management process which is uniform for everyone is, in effect, the price of receiving services through a national long-term care program, and they might assume that people will be willing to accept case management to get the services—probably a reasonable assumption in general. On the other hand, case management is an expensive addition to the cost of long-term care services.⁶ Policy makers might prefer to limit the case management that is required for everyone who receives services through a national long-term care program to only those administrative tasks that are essential to allocate services in accordance with program regulations. Case management beyond those administrative tasks might be provided only for people who are identified as needing it by some specified criteria.

Many commentators have noted that families of frail older people frequently perform case management tasks, acting as intermediaries between the older person and paid service providers (20,22,24,44,45,59,64). Some commentators have suggested that maximizing families' performance of case management tasks might increase the family's satisfaction with services, meet patients' needs more appropriately, minimize costs, and eventually decrease the need for a paid case manager (31,59,60,62). Few attempts have been made to help families become better case managers (27) but one project that did train and assist some families of elderly people to perform case management tasks found that the families who received the training and assistance accomplished significantly more case management tasks than did a control group of families that did not receive the training and assistance. Additionally, the total duration of services was significantly shorter for the older people whose families received the training and assistance than for older people whose families did not (59).

A national long-term care program could attempt to maximize families' performance of case management tasks. Doing so would alleviate the concerns of some families that the case manager will take over control of their relative's care. Families differ, of course, and whether a specific family is able to perform case management tasks depends on the characteristics of the family and the caregiving situation. Determining which families could successfully perform case management tasks (with or without training and assistance) would require difficult judgments by case managers in at least some instances. To make these judgments and to help families become better case managers would require special skills on the part of the case managers.

Some individuals who need long-term care services also may be able to function as their own case manager. OTA's work with respect to long-term care services and service delivery mechanisms has focused primarily on people with dementia, the great majority of whom are not able to function as their own case manager, that is, they cannot define their service needs, locate or arrange services themselves, or monitor or evaluate the services, etc. (67). Some elderly people and disabled people who need long-term care and do not have dementia may be able to perform some or all of these tasks themselves.

If the objectives of a national long-term care program were to include maximizing families' and individuals' performance of case management tasks (except for the administrative tasks involved in allocating services in accordance with program regulations), several requirements would have to be met. First, there would have to be a clear mandate that this was an objective of the program. Second, there would have to be guidelines for implementing the objective, and third, there would have to be training for case managers to help them achieve the objective.

A final issue related to the question of who should receive case management in a national long-term care program is whether the program should provide case management for people who are not eligible for the services (nursing home care, in-home services, adult day care, etc.) provided by the program. Recent proposals for a national long-term care program would provide case management only for people who meet the eligibility requirements for the program (i.e., 2 or 3 ADLs, or a combination of ADLs, IADLs, and cognitive impairment). Some State long-term care programs that are means-tested provide case management for people who do not meet the financial eligibility criteria for the programs (35), and several States provide case management for some people with dementia who do not meet the functional eligibility re-

⁶ Capitan, et al. (1986) reported average case management costs ranging from \$47 to \$134 per client per month for 5 long-term care demonstration programs (25). The average cost of case management for the National Long-Term Care Channeling Demonstration was \$85 per client per month (46). Kane et al. (1989) reported case management costs ranging from \$96 to \$123 per client per month in 44 long-term care programs, including both operational and demonstration programs (39).

quirements for the States' long-term care program (67). OTA's study of methods of linking people with dementia to appropriate services indicates that some people with dementia who do not meet the proposed eligibility criteria for a national long-term care program nevertheless need case management (67). The same is undoubtedly true for some elderly and disabled people who do not have dementia.

If a national long-term care program provided case management for certain people who were not eligible for services through the program, it would increase the cost of the program. On the other hand, providing case management for those people would help to connect them to appropriate services and perhaps would make the national program more acceptable to individuals who need long-term care services but are not impaired enough to receive services through the program.

What Agencies Should Provide Case Management in a National Long-Term Care Program?

In its study of methods of linking people with dementia to services (67), OTA analyzed many agencies' current and potential capacity to provide case management and three other linking functions—public education, information and referral and outreach—for people with dementia. OTA analyzed some State programs that provide case management for elderly and/or disabled people, as well as 11 categories of agencies that could conceivably be designated from the Federal level to provide case management for people with dementia.⁷ Although the focus of the OTA report is not the allocation of long-term care services or funding for services, the following findings of the OTA study may be helpful in thinking about what agencies should be designated to provide case management for a national long-term care program.

- Case management differs greatly from one agency to another and from one category of agencies to another. Even in agencies that purport to provide the five case management functions listed earlier in this paper, the case management that is provided varies greatly. Therefore, the fact that an agency or a category of agencies provides "case management" is not

an indication that the agency or category of agencies is capable of providing the case management that will be needed in a national long-term care program.

- A very large number of agencies and categories of agencies provide or perceive themselves as providing case management for people who need long-term care. There are intense turf issues among these agencies that emerge whenever a suggestion is made that one agency or one category of agencies should be the case manager. These turf issues reflect the agencies' perception that the agency that is designated as the case manager will control what services are used and who gets paid for providing them.
- Some States have developed consolidated long-term care service programs in which case management is a central component. These States have designated a single agency in each locality as the case management agency. In some of the States, the agency designated to provide case management at the local level has been changed one or more times after the State program was instituted. In designating local case management agencies, the States have confronted intense turf issues, and resolving the turf issues has required time and, in some cases, certain concessions to agencies or categories of agencies that were not selected as the case management agency.
- Even in States that have not developed consolidated long-term care service programs, there are State and local government agencies and private agencies that provide case management for State programs. These agencies vary greatly from one State to another.

Some conclusions that can be drawn from these findings are that a policy decision about which agencies will provide case management for a national long-term care program will engender intense turf issues; that the agencies that are best-qualified to provide case management for a national long-term care program differ from one State to another; and that designating a single category of agencies to provide case management nationwide would require States to change their current case management programs and would confound the ongoing efforts of some States to develop and maintain consolidated long-term care programs. All of these conclusions point to the wisdom of allowing each State to designate the agencies that will provide case management for the national long-term care program as it is implemented in that State.

One of the most controversial issues with respect to determining which agencies should provide case man-

⁷ The 11 categories of agencies included in OTA's analysis of agencies that could be designated from the Federal level to provide case management and other linking functions for people with dementia are: area agencies on aging, community mental health centers, community health centers, Alzheimer's Association chapters, replications of Family Survival Project, regional Alzheimer's diagnostic and assessment centers, hospital-based geriatric assessment programs, home health agencies, health maintenance organizations (HMOs) and SHMOs, replications of On Lok, and adult day centers.

agement for a national long-term care program is whether agencies that provide services other than case management (home health care, senior services, etc.) should be excluded from consideration. This issue is more complex than one might assume from the policy debate at the Federal level, which generally concludes that agencies that provide services should be excluded from consideration because these agencies have a financial incentive to refer clients to their own services rather than to the services of other agencies and to authorize too many services for clients. Only a few of the complex aspects of this issue are noted here. A full analysis of the issue is needed.

First, as noted earlier, some agencies provide service-centered case management (i.e., case management that is provided in conjunction with the provision of a particular service) and other agencies provide comprehensive case management (i.e. case management that takes place independent of the provision of any particular service). Clearly, a national long-term care program would require comprehensive as opposed to service-centered case management. That does not mean, however, that agencies that provide services, such as home health care agencies and mental health agencies, could not provide case management for the program. That agencies which provide services can also provide comprehensive case management is illustrated by the home health care and mental health agencies that provided comprehensive case management for the National Long-Term Care Channeling Demonstration (46) and by the home health care, mental health, and senior service agencies that provide comprehensive case management for Illinois' Community Care Program (35).

The experience of the National Long-Term Care Channeling Demonstration indicates that case managers in agencies that provide services can be effectively insulated from pressures to refer clients to their own agencies' services, rather than to other agencies' services that may be more appropriate for the client, and pressures to over-prescribe services (14). On the other hand, in Illinois, the agencies that provide case management for the State's Community Care Program are prohibited from providing other services through the program. An analysis of practices in existing programs that allocate long-term care services or funding for services with respect to this issue would be helpful in deciding whether agencies that provide services should provide case management for a national long-term care program.

A related question is whether or to what extent the long-term care program should provide case management for people who are receiving case management from another agency in conjunction with services

they get from that agency. OTA has become aware of this question through conversations with several staff members of agencies in Cleveland, Ohio, where the State is implementing PASSPORT, a comprehensive long-term care program that has been in effect in other parts of the State for several years. PASSPORT's case management procedures are central to the administration of the program. On the other hand, some agency staff members in Cleveland believe that, in general, people who are eligible for PASSPORT should receive case management from the agencies that provide services for them, and that providing case management through PASSPORT would duplicate the efforts of those agencies.

This is a question that can be expected to arise repeatedly in the implementation of a national long-term care program. It is unclear how it should be resolved. An analysis of the ways in which it is handled in existing agencies that allocate long-term care services or funding for services is needed to inform Federal policy decisions in this area.

Within The Agencies That Provide Case Management for a National Long-Term Care Program, Who Should Be the Case Managers

Virtually all health care, social service, and other human service professionals and service providers "manage" their clients in some sense. Nurses and social workers are the case managers in some agencies that allocate long-term care services or funding for services. Other such agencies employ as case managers individuals with a college, but not a professional degree in a human service field (15).

Differences of opinion about who should be the case manager usually focus on social workers vs. nurses and involve competing claims about the knowledge and skills that case managers need and which group has that knowledge and those skills (7,9,14,28,30,36,49,53). Those differences of opinion often reflect intense turf conflicts. In many agencies, however, social workers and nurses work together constructively and comfortably, learning from each other and relying on each other's unique knowledge and skills. Many commentators, including some of those who have noted the turf issues between social workers and nurses, have concluded that both are needed for effective case management (7,9,41,56). That seems to be a wise conclusion.

Some commentators have emphasized that regardless of their education and training, case managers

who work for programs that allocate long-term care services or funding for services need training to follow standardized assessment and care planning procedures and to include cost consciousness in the factors they consider in authorizing services for clients of the program (1,2,9,34,37,39,58). This report has suggested several other areas in which special training might be needed for case managers—for example, in balancing the conflicting demands of the “gatekeeping” and clinical/helping roles, in determining which clients of a long-term care program need case management beyond the administrative tasks that are essential to allocate benefits, and in helping families become better case managers.

CASE MANAGEMENT STANDARDS

The American Nurses’ Association, the National Association of Social Workers, the National Council on the Aging, and Ohio’s PASSPORT program, and perhaps other organizations have formulated case management or “care management” standards (6,10,51,52). OTA has not compared those standards systematically, but a brief review indicates that they are based on similar views about the role and practice of case management. Policy makers might consider incorporating some of the core features of those standards into a national long-term care program.

What Role Should the Case Management Component of a Long-Term Care Program Play With Respect to the Quality of Services to Which it Connects People?

The quality of all kinds of long-term care services varies greatly from one agency and individual service provider to another. Numerous reports document the poor quality of care provided by some nursing homes (50,68) and home care agencies (32,66,69), for example. At the same time, these reports indicate that other nursing homes and home care agencies provide excellent care. Differences in quality are typical not only of these types of services, but of all kinds of long-term care services.

In theory at least, a long-term care program could take several different approaches with respect to the quality of the services to which it connects its clients. It could not concern itself with the quality of the services, and rely on its clients, their families, and others who are concerned about quality to obtain for themselves any information they need to evaluate the services. It could inform its clients that there are significant differences in the quality of available services.

It could refer its clients to specific sources of information about the quality of available services or provide its clients with information about the quality of available services. Lastly, it could arrange and pay for only services that met specified standards of quality (67).

In practice, the implementation and effectiveness of any of these approaches would be hampered by the lack of agreed-upon standards for evaluating the quality of many types of long-term care services and the lack of sources of accurate information about the quality of services (67). The development of standards for evaluating the quality of all types of long-term care services is an important priority in the implementation of a national long-term care program.

Some programs that allocate long-term care services or funding for services have developed procedures for monitoring and controlling the quality of the services to which they connect their clients. Certain of these programs provide services and therefore can assure (i.e., assess and correct problems in) the quality of those services directly. Other programs contract and/or pay for services; these programs cannot assure the quality of services provided by any particular agency or individual, but they can use their contracting and reimbursement procedures to select service providers that meet certain standards (see, for example, Applebaum, et al., 1988 (10); Balmer, 1988 (17); Dolan and Holtz, 1986 (26); Mumma, 1987 (48); Torres, 1988 (65)).

Many commentators have suggested that case managers can monitor and control the quality of long-term care services generally (4,16,27,29,37,57,70), and most of the programs that have developed procedures for monitoring and controlling the quality of services to which they connect their clients involve case managers in that process. Case managers do not automatically monitor and control quality, however. Their functions vis-a-vis quality vary greatly, depending on factors such as the organization, funding, sponsorship, and policies and procedures of the agency that employs them.

A recent review of the experiences of case managers in the National Long-Term Care Channeling Demonstration illustrates some of these differences (11). The Channeling Demonstration, which was funded by the U.S. Department of Health and Human Services from 1980 to 1985, took place in 10 sites: in 5 sites, the case managers had funds to purchase services, and in five other sites they had only very limited funds. Case managers in both types of sites had difficulty controlling the quality of homemaker and personal care services received by their clients. Some

sites had contracts with homemaker/home health aide agencies, and at those sites, procedures for monitoring quality and responding to inadequate services were detailed in the contracts. At sites that did not have contracts with service providers, procedures for monitoring quality and responding to problems were less structured and less formal. Sites that had funds to purchase services used the threat of withholding payment to pressure providers into improving their services. That option was not available to sites that did not have funds to purchase services.

These findings from the Channeling Demonstration and the findings of some State programs that allocate long-term care services or funding for services (e.g., Ohio's PASSPORT program and Pennsylvania's LAMP program) suggest that it is not case managers per se that monitor and control the quality of long-term care services but rather case managers in an agency or program that has explicit procedures for this purpose. Policy makers should not assume that simply involving case managers in a long-term care program will guarantee that the program will monitor and control the quality of services.

Finally, OTA's analysis of the potential role of case managers and case management agencies with respect to the quality of services for people with dementia suggests that case managers may be legally constrained from referring clients to services based on the case managers' judgments about the quality of the services. A 1987 Oregon case *Bionic Health Care, Inc. v. State of Oregon Department of Human Resources, et al.* (19) concerned a situation in which case managers who worked for a public agency had stopped referring clients to one nursing home that they believed was providing poor care and that was under review by the State licensing and certification agency. The nursing home sued, arguing that it had a valid State license and was certified by Medicare and Medicaid and that the case managers could not refuse to refer clients there. The nursing home won, and the case managers have been instructed not to make recommendations to clients about service providers.

OTA has no information about how often case managers in programs that allocate long-term care services or funding for services recommend certain service providers on the basis of quality. One member of the advisory panel for the OTA study interviewed case managers who refer people to nursing homes found that the case managers generally believed that they were legally constrained from making referrals on the basis of quality (38). An analysis is needed of any legal constraints or legal risks that may be incurred by a long-term care program and the agencies and case managers that implement it when the case managers authorize services on the basis of their quality.

CONCLUSION

This paper has discussed several different aspects of case management and has suggested ideas and options that policy makers could consider in designing the case management component of a national long-term care program. Because of the widespread uncertainty, confusion, and disagreement about what case management is, it would be easy for policy makers to leave difficult policy issues unresolved, to be worked out in the case management process. Some of the policy issues that could be left unresolved are: what kinds of people are eligible for what kinds of services; whether the relative emphasis in the program is on cost containment or providing more services for people; what the role of clients and their families should be in decisions about the services they will receive; and whether the long-term care program will be responsible in any way for the quality of services to which it connects people and if so, how. People who need long-term care are extremely diverse, so the application of policy decisions in each of these areas to an individual client's situation must be left to the case manager's judgment. The basic policy decisions—that create the program structure within which case managers will make judgments about individual client's situations—should be made, however, by those who design the system.

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ROLE OF FEDERAL AND STATE GOVERNMENTS AND VOLUNTARY ORGANIZATIONS IN ASSURING QUALITY OF CARE IN SELECTED LONG-TERM CARE SERVICES

Carol O'Shaughnessy and Richard Price *

This is in response to your request for information on the role of Federal and State Governments and voluntary organizations in assuring quality of care for selected long-term care services. For purposes of our review, we have defined long-term care services as being provided in four distinct settings: (1) nursing homes, (2) the home, and (3) adult day care, and (4) board and care homes. Home care includes both home health care and nonmedical supportive services, such as personal care, homemaker, and chore services. This memorandum discusses Federal and State requirements and the activities of voluntary organizations aimed at assuring quality of care in each of these settings.

INTRODUCTION

Assessment of quality care in long-term care services generally includes three components: establishment of standards of care; monitoring the degree to which standards are met; and enforcement of standards. Assessing quality of care for long-term care services is difficult, due partially to the wide range of settings in which long-term care services are provided and the complex needs of chronically impaired populations. Settings range from skilled nursing homes where patients receive intensive nursing services to home and community-based services which respond to a variety of supportive service needs. Federal efforts to assure quality has generally been devoted to the review of the structure and process by which long-term care providers deliver services, for exam-

ple, by focusing on the organization of the provider, and staff qualifications and training. Recently some Federal attention has been directed at client-centered assessment procedures in nursing homes and home health services.

Although a number of Federal programs support long-term care services—primarily Medicaid, Medicare, the Social Services Block Grant Program (SSBG), the Older Americans Act, and the Supplemental Security Income (SSI) Program—Federal requirements for assuring quality of care through the establishment, monitoring, and enforcement of standards vary significantly across these programs. In part because of the large commitment of Federal dollars to nursing home care under the Medicaid and Medicare programs, concern with quality of long-term care services has focused on this particular setting during the past two decades. However, in the past few years, quality of home care has also become an important issue for policymakers. This relatively new interest has come with awareness of a rapidly growing home health care industry and increasing expenditures under the Medicare program. The number of home health agencies participating in Medicare has more than doubled in less than a decade—from 2,858 in 1979 to 5,769 in 1988. Program payments for home health care increased from \$542 million in 1979 to \$2.6 billion in 1988. Quality issues in home care have also arisen as the nature of services delivered in the home has changed and as more technologically intensive services requiring greater expertise from home care personnel have come on the market. In addition, quality of home care has become more prominent as Congress considers a variety of proposals to increase Federal support for home and community-based care.

* Prepared for the U.S. Bipartisan Commission on Comprehensive Health Care (The Pepper Commission), by Carol O'Shaughnessy and Richard Price, Specialists in Social Legislation, Education and Public Welfare Division, Congressional Research Service, August 25, 1989.

While each of the programs mentioned above support home care services, only the Medicare and Medicaid programs contain specific Federal requirements pertaining to standards of care for home health care services. The establishment, monitoring, and enforcement of standards for nonmedical home care services, such as homemaker and chore, is the responsibility of State government. Similarly, the responsibility for oversight of the quality of adult day care programs and board and care facilities rests with States. State policies vary significantly as to methods used to assess quality and to monitor and enforce standards for these community-based services.

NURSING HOME CARE

The National Nursing Home Survey of 1985, the latest national survey of nursing homes in the country, estimates that there were approximately 19,100 nursing and related care homes at that time. These nursing homes had 1.6 million beds and about 1.5 million residents. The services provided by these facilities range from highly skilled medical, nursing, and rehabilitative services to health-related, personal and supportive care for persons with chronic impairments.

Federal Requirements

Medicare and Medicaid—Medicare and Medicaid law and regulations specify requirements that nursing homes (skilled nursing facilities, in the case of Medicare, and skilled nursing facilities and intermediate care facilities (ICFs), in the case of Medicaid) must meet in order to participate in these programs. In general, these requirements specify standards for staffing, provision of services, and organization that are intended to assure the health and safety of residents. In order to determine that nursing homes meet these requirements, the Secretary of Health and Human Services (HHS) enters into agreements with States to survey facilities on an annual basis. Nursing homes that are found by State survey agencies (generally, the State's licensure and certification agency) to comply with requirements are certified for participation. The Health Care Financing Administration (HCFA), for nursing homes wishing to participate in Medicare, and State Medicaid agencies, for nursing homes wishing to participate in Medicaid, then decide whether to enter into an agreement with a nursing home to allow the facility to receive reimbursement under the programs. According to the National Nursing Home Survey of 1985, 76 percent of all nursing homes and 89 percent of all beds in these facilities

were certified to participate in Medicare and/or Medicaid at that time.

Recently, the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) included provisions, commonly referred to as nursing home reform, that comprehensively revise the statutory authority for nursing home certification. Implementation of these provisions is to be phased in from 1988 through 1991, with major sections of the new law becoming effective October 1, 1990. When these provisions become fully effective, they will—

- establish in Medicare and Medicaid law a very similar set of requirements that nursing homes must meet in order to participate in the programs, including requirements as to the scope of services nursing homes must provide, levels of staffing in the facility and qualifications of staff, assessment of each resident's functional capacity, and residents' rights, among others;
- require an unannounced standard survey of nursing homes that is focused on residents and outcomes of the care they receive, as well as extended surveys for those facilities found to be providing substandard care; and
- expand the sanctions that States and HCFA may impose against noncompliant nursing homes.

The enclosed CRS report, *Medicare and Medicaid Nursing Home Reform Provisions in the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203*, provides additional background information on nursing home certification under Medicare and Medicaid, as well as a detailed summary of the enacted legislation.

In addition to requirements for the certification of nursing homes wishing to participate in Medicare and/or Medicaid, the Omnibus Budget Reconciliation Act of 1986 (OBRA 86) contained two provisions authorizing peer review organizations (PROs) to review the quality of care provided Medicare beneficiaries in post-hospital settings, including nursing homes. One provision requires PROs to review early readmissions of Medicare beneficiaries to hospitals (those occurring within 31 days of a previous hospital discharge) to determine if inpatient hospital and post-hospital services, including skilled nursing facilities, meet professionally recognized standards of care. OBRA 86 also requires PROs to allocate a reasonable portion of their activities to review the quality of services among different cases and settings, including post-acute services provided by skilled nursing facilities, regardless of whether a readmission has taken place. HCFA has chosen to implement only the readmission requirement of OBRA 86, arguing that the existing

survey and certification process addresses the second requirement.

Older Americans Act—While Medicare and Medicaid requirements for certifying nursing homes have generally focused on quality of care by review of facilities' compliance with standards related to services, staffing, and health and safety of residents, another Federal program takes a consumer-based approach to defining quality of care. Under provisions of the Older Americans Act, each State agency on aging must establish a State long-term care ombudsman office which is responsible for investigating and resolving complaints made by, or on behalf of, residents of nursing homes, board and care facilities, and other adult care homes. Ombudsmen are required to investigate and resolve complaints of residents¹ related to the action, inaction, or decisions of long-term care providers, or their representatives, or of public agencies and social services agencies which may adversely affect residents' health, safety, welfare, or rights. Under provisions of the Older Americans Act and OBRA 87, ombudsmen are required to have access to long-term care facilities and to patient records. OBRA 87 also required that State agencies responsible for surveying nursing homes share the results of their Medicare/Medicaid surveys with the State long-term care ombudsman.

The Older Americans Act specifies a number of other requirements aimed at assuring that the ombudsman program act as an advocate on behalf of residents on a statewide basis. In addition to individual resident complaint investigation, the law requires ombudsmen to analyze and monitor the implementation of Federal, State, and local policies affecting residents and to appropriate actions to improve quality of care. Ombudsmen are also required to develop a statewide reporting system to identify and resolve significant problems in facilities and to submit this information to the State agency responsible for licensing or certifying long-term care facilities.

While Older American Act funds are available to support ombudsman staff at both the State and local levels, to a large extent the program relies on volunteer ombudsmen. In FY 1987, out of over 9,800 staff devoted to the ombudsman program, about 88 percent were volunteers. The Administration on Aging (AoA) reports that in FY 1987 over 110,000 complaints were

received by ombudsmen, a 63 percent increase since FY 1982.²

State Regulation

In addition to surveying nursing homes for Medicare and/or Medicaid certification, States, through their licensure and certification agencies, also conduct licensure inspections of nursing homes. As noted above, not all nursing homes are Medicare/Medicaid certified. For certified and non-certified facilities alike, all States have licensing laws pertaining to nursing homes that specify requirements nursing homes must meet in order to operate in the State. As is the case with Federal regulation, State licensing includes: (1) requirements for provision of services, staffing, and assuring the health and safety of residents; (2) inspections of facilities; and (3) sanctions and penalties that may be imposed against deficient nursing homes. Certain States use Medicare/Medicaid certification requirements as a foundation for their licensing laws and may include additional requirements for nursing homes to operate in the State.

An Institute of Medicine (IOM) survey of the directors of State licensure and certification agencies, as reported in *Improving the Quality of Care in Nursing Homes*, found that just over half (24/47) of the respondents judged their State's licensure requirements for intermediate care facilities more stringent than those of the Federal Government; one-quarter (11/47) said they were the same; and one-quarter (12/47) said they were less stringent.³ One-third (17/47) of the directors stated that their State's licensure requirements for skilled nursing facilities are more stringent than the Federal requirements; one-third (14/47) said they were about the same; and one-third (14/47) said they were less stringent.

According to this IOM survey, most agencies conduct licensure inspections once every 12 months (40/47).⁴ Nearly all State survey agencies indicated that they have at least several licensure sanctions available to them, but very few were applying any formal sanctions, State or Federal. The IOM survey found that 85 percent of the total actions against noncompliant nursing homes were taken in 13 States.⁵

¹ The Older Americans Act supports services and programs for persons aged 60 and over. According to an analysis by the National Association of State Units on Aging (NASUA), of 35 States which have enacted State laws pertaining to the ombudsman program, 22 laws do not specify an age limitation for residents who may receive ombudsman services. NASUA, *An Analysis of Policies and Procedures of State Long Term Care Ombudsman Offices* (September 1988), 31.

² Administration on Aging, *FY 1988 Report to Congress on Long-Term Care Ombudsman Activities Under Title III of the Older Americans Act, FY 1987* (December 1988).

³ Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (Washington, D.C.: National Academy Press, 1986), 319-320.

⁴ Institute of Medicine, *Improving Quality*, 320.

⁵ Institute of Medicine, *Improving Quality*, 321.

Voluntary Organizations

Nursing homes may voluntarily obtain accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), as meeting certain standards for providing quality care. Specifically, JCAHO accredits nursing homes that are licensed by their States and have 24-hour registered nurse coverage. About 1,100 nursing homes have been accredited by JCAHO. Accreditation surveys are announced in advance and include on-site observations of the facility. If it is found to be in substantial compliance with Joint Commission standards, a facility is awarded accreditation for 3 years and is not resurveyed until the end of its accreditation cycle (although JCAHO may conduct interim surveys for organizations accredited with certain kinds of problems). According to JCAHO, standards for accreditation are similar to requirements for Federal certification.⁶

HOME CARE

Home care is a generic term encompassing a number of different services and functions. Home care services range from highly complex functions provided by skilled personnel, such as registered nurses and therapists, to personal care and housekeeping services provided by nontechnical personnel such as home health aides and homemakers. There are no uniform Federal standards by which to judge the quality of the broad range of home care services supported by each of the major Federal funding sources. Medicare finances home health services provided by agencies which must meet federally prescribed requirements. However, other Federal programs, such as the Older Americans Act and the SSBG, provide funds for nonmedical home care services to State agencies which have wide flexibility in defining quality of care. A recent study of State home care quality assurance programs indicated that this fragmented accountability makes assurance of quality of care difficult to achieve.⁷

The total number of home care providers which provide one or more home care services is difficult to gauge. There are about 6,000 Medicare-certified home health agencies. It is estimated that another 6,000 agencies provide services similar to Medicare's home health benefits (as well as other paraprofessional home care services) but are not certified by Medicare.⁸ In

addition, according to the National Association for Home Care (NAHC) the number of agencies providing only nonmedical supportive home care services, such as homemaker and chore services, is estimated to be about 4,000 to 6,000. The total number of agencies providing home care services may be as high as 20,000.

Federal Requirements

Medicare and Medicaid—The Medicare program covers a variety of medically-related home health services for persons who meet certain qualifying criteria. Covered services must be provided by a home health agency that is certified to participate in the program. Medicare law and regulations specify the requirements that home health care agencies must meet in order to participate. These requirements specify standards for staffing, provision of services, and organization that are intended to assure the health and safety of residents. As in the case of nursing home care, the Secretary of HHS uses State licensure and certification agencies to survey home health agencies to determine their compliance with these requirements.

OBRA 87 included provisions that revise the certification process for home health agencies participating in Medicare. The approach adopted in OBRA 87 for assuring quality home health care is similar to the approach used for nursing home care. Specifically, OBRA 87—

- establishes new requirements for home health agencies that emphasize patients' rights and training of home health aides;
- requires an unannounced standard survey that includes visits to patients' homes and an extended survey of those agencies found to be providing substandard care; and
- expands the sanctions that may be imposed against agencies that do not comply with the requirements for participation.

OBRA 87 contained certain other related provisions. It requires that State or local survey agencies maintain a toll-free hotline (1) to collect, maintain, and continually update information on home health agencies certified to participate in Medicare, including information on deficiencies in providing care, corrective actions, and sanctions imposed, and (2) to receive complaints and answer questions about agencies. OBRA 87 also requires States to maintain a unit that can investigate complaints and that has enforcement

⁶ This information was obtained in a telephone conversation with JCAHO on Aug. 14, 1989 and from JCAHO's 1988 *Long-Term Care Standards Manual*.

⁷ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Review of State Quality Assurance Programs for Home Care* (April 1989), sec. I, 3.

⁸ Charles Sabatino, "Homecare Quality," *Generations* (Winter 1989): 13.

authority and access to survey and certification reports and consumer medical records.

In addition to Federal certification requirements, the OBRA 86 requirements described above for PROs to review the quality of care provided to Medicare beneficiaries in post-hospital settings apply to home health care. As noted, HCFA has chosen to implement only the readmission requirement of OBRA 86, arguing that the existing survey and certification process addresses the more general requirement for reviewing the quality of post-hospital services, including home health care.

States also cover home health services under their Medicaid plans. The Federal Medicaid statute does not define the term home health services. However, Medicaid regulations require States to include a minimum range of home health services in their Medicaid programs. These include nursing services, home health aide services, and medical supplies and equipment. At the State's option, home health services may also include physical and occupational therapy, speech pathology, and audiology services.

Under Medicaid, home health services are provided by home health agencies or facilities licensed by the State to provide medical rehabilitation services. Although the law does not define the term home health agency, Medicaid regulations define it as a public or private agency or organization, or a subdivision of such an agency or organization, that meets the requirements for participation in the Medicare program.

States, at their option, may also cover personal care services under their Medicaid plans. In 1987, 26 States did so. Medicaid regulations require that personal care services be provided in a beneficiary's home and be prescribed by a physician in accordance with a recipient's plan of treatment. These services must be provided by an individual who is qualified to provide the services, who is supervised by a registered nurse, and who is not a member of the recipient's family. States have a great deal of flexibility in defining who is qualified to provide personal care services. In general, Medicaid allows States to follow their own procedures for certifying noninstitutional providers of care. Medicaid regulations contain a general requirement that a State's plan include a description of methods and standards used to assure that services are of high quality. This would apply to personal care providers and State determinations as to who is a qualified provider of these services.

Finally, Medicaid authorizes States to cover a variety of nonmedical community-based services under home and community-based waivers, often re-

ferred to as "2176 waivers." Services which may be provided under the waiver include case management, homemaker/home health aide services, personal care services, adult day health care services, habilitation services, respite care, and other services. As of March 31, 1989, 48 States had waivers to provide home and community-based services to aged and disabled, mentally retarded, and/or mentally ill persons who would otherwise require institutional care. To have a waiver request approved by HCFA, a State must provide satisfactory assurances to the Secretary as to the safeguards taken to protect the health and welfare of recipients of services. Medicaid regulations implementing this provision of law require that these safeguards include (1) adequate standards for all types of providers that provide services under the waiver; (2) assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and (3) assurance that all board and care facilities in which home and community-based services will be provided are in compliance with Federal and State requirements for facilities in which a significant number of SSI recipients reside.

Social Services Block Grant Program—The SSBG provides funds to States for a broad range of social services. The Federal law gives States wide discretion as to what services to provide as long as services meet certain general goals, such as preventing or reducing inappropriate institutional care. In FY 1988, 45 States planned to provide a range of nonmedical home-based services to individuals and families under their State SSBG plans.⁹ Home-based services are defined as homemaker, chore, home health, companionship, and home maintenance. There are no Federal requirements related to standards for home-based care provided with SSBG funds.

Older Americans Act—Under the Older Americans Act, each State agency on aging receives funds for home care services.¹⁰ Funds are administered in local communities by area agencies on aging. As is the case under the SSBG, title III provides funding for nonmedical home care services, including homemaker, home health aide, and chore services, visiting and telephone reassurance, and respite care for family caretakers. Although the law does not contain specific

⁹ This information was provided in a telephone conversation with the Office of Human Development Services staff. Under provisions of the SSBG, States are required to submit to HHS information on the intended use of funds for the upcoming fiscal year.

¹⁰ Funds are provided to States under title III-B of the Older Americans Act for a broad range of social services. Under title III-B home care services are considered a priority service. State agencies are required to specify what proportion of title III-B funds are to be spent on home care services by each local area agency on aging. In addition to the authority under title III-B, the 1987 amendments to the Act created a separate authorization of funds for in-home services for the frail elderly under a new title III-D. Each State receives a separate allotment of funds for such services.

requirements related to quality of home care services, such as the development, monitoring, or enforcement of standards of care, both title III law and regulations contain general requirements that State and area agencies are to conduct periodic evaluation of services provided under State and area plans on aging. In keeping with the advocacy role intended for area agencies on aging, the law specifically charges area agencies with responsibilities for monitoring service programs affecting the elderly. In addition, under the Federal statute area agencies are responsible for coordinating services provided under title III with other service providers.

In addition to the mandate under title III of the Older Americans Act, some activity with respect to home care quality assurance has been undertaken under the title IV research and demonstration authority. In FY 1988 AoA funded 12 States to carry out a variety of quality assurance projects.¹¹

State Requirements

As indicated above, Medicaid requires States to certify Medicaid-funded home health care providers using criteria based on the Medicare requirements for participation. Beyond Federal certification, State requirements aimed at quality of home care vary widely. The most common form of State regulatory action is State licensure policies requiring agencies providing home health care services to meet certain standards before being authorized to operate in the State. According to the NAHC, 39 States have licensure requirements for home health care agencies.¹² Relatively few States apply licensing requirements to agencies which provide nonmedical home care services.

A recent DHHS-sponsored study, *Review of State Quality Assurance Programs for Home Care* (April 1989), surveyed 19 States to identify their home care quality assurance mechanisms. The study looked at standard setting and monitoring and enforcement pro-

cedures and found great variation in quality assurance methods employed as well as implementation strategies.

The study identified the following standards used by one or more States to measure or assess quality: (1) training requirements for home care workers, such as specification of number of hours of required training, competency testing, and/or prescribed curriculum; (2) certification or registration of workers who meet certain State-prescribed training programs; (3) licensure of providers; (4) accreditation of providers according to criteria developed by an independent accreditation body such as the Joint Commission on Accreditation of Healthcare Organizations, the National League for Nursing, or the National HomeCaring Council; (5) requirements for State approval of agencies or providers (usually applied to nonmedical home care providers); (6) establishment of client bill of rights; (7) requirements for a code of ethics for aides; (8) criminal record checks on workers; and (9) requirements for minimum pay levels for workers. The most frequently reported standards used by the States in this survey were training requirements for workers and licensure of providers (the latter usually applies to home health agencies rather than nonmedical home care providers). Other standards were used less frequently.

The study also identified a number of monitoring mechanisms used by States to determine compliance with standards, and found considerable variation among methods used. For example, while the most frequent means of monitoring was worker supervision, requirements ranged from minimum to frequent supervision. Provider surveys are universally used to monitor home health agencies and are tied to Medicaid certification, State licensing and accreditation procedures. In some cases provider surveys are also used for monitoring nonmedical home care services. Other common monitoring mechanisms were case management procedures (more common with nonmedical home care providers) and contract reviews. Few programs monitored the impact of services on clients.

The survey found that the most frequently used enforcement mechanism used by States were economic penalties, such as cancellation, denial, or suspension of provider contracts, or withholding of funds. Other economic penalties included reassigning clients to competing providers, withholding referrals, and limiting the extent of a provider's service delivery (e.g., limiting services to specified geographic areas or the type of service that may be provided by individual providers). Economic penalties were found to be influenced by availability of providers.

¹¹ Projects are listed in *Compendium of Active Grants Under Title IV of the Older Americans Act*, Nov. 1988. Also, the 1987 amendments to the Older Americans Act authorized the Commissioner on Aging to demonstrate and evaluate the effectiveness of consumer protection for older persons who receive publicly funded home care services. These projects are to provide consumer protection through State and local ombudsman, legal assistance agencies, and may include the use of hotlines, complaint investigation, and advocacy. FY 1989 and FY 1990 funding for these projects is subject to a trigger (no funds may be appropriated unless funding for the Act increases by 5 percent over the FY 1987 level). No funding was appropriated in FY 1989.

¹² National Association for Home Care, *Home Care, State Licensure and Certificate of Need* (March 1989). This includes the number of States that license Medicare certified as well as non-Medicare certified home health agencies. According to this analysis, there are seven States which apply licensure policies to Medicare certified providers, but which do not license non-Medicare certified providers. In addition, two States license non-Medicare certified agencies but do not license certified providers.

Quality assurance mechanisms also vary according to funding source. The survey found that health and medically related home care programs funded by Medicaid had more formal quality assurance requirements than programs funded by the SSBG or the Older Americans Act. This is because Medicaid home health providers are required to meet the Medicare conditions of participation for home health services. Both the SSBG- and Older Americans Act-funded programs frequently had worker training requirements although great variation existed in the type of training requirements. Both SSBG and Older Americans Act programs relied on worker supervision and case management techniques to monitor services although again the study found great variation in the way in which such monitoring is carried out. Both programs also relied on economic sanctions as means to enforce standards.

Attachment A presents a detailed listing of State quality assurance mechanisms used by States for home care programs funded under Medicaid's personal care option and 2176 waiver programs and the SSBG and Older Americans Act programs.

Another means of monitoring home care services used by a few States is the Older Americans Act long-term care ombudsman program. According to the HHS study on home care quality assurance, five States have a specific legislative mandate to expand the ombudsman program to home care (Wisconsin, Wyoming, Maine, Virginia, and Minnesota). In another State (New York) some local ombudsmen handle complaints of some home care recipients. In none of these States are the programs fully operational statewide. Although some officials believe that the ombudsman concept can be useful in assuring quality of care, the HHS report indicated that they do not see it as a major quality assurance tool. Reasons for this include the fact that the ombudsman role is a problem-solving tool for individuals and not a monitoring tool; funding for the ombudsman program is limited and the program is already overburdened with complaint resolution for residents of facilities; and recipients of home care services may be resistant to filing complaints against a home care provider if their only alternative is nursing home placement.¹³

Voluntary Organizations

If they wish to do so, home care providers may voluntarily obtain accreditation from organizations that survey providers to determine whether they meet

standards for providing quality care, as defined by the accrediting organization. With the assistance of professionals in the field, three national organizations have established such standards for home care providers.

The National Homecaring Council (NHCC) has established recommended standards and an accreditation program for homemaker/home health aide services. This accreditation program involves peer review of homemaker/home health aides services only. The standards cover four components for the administration of homemaker/home health aide services, including structure of the agency, staffing, services provided, and community activities. The accreditation program includes agency self-study and an on-site peer review by Council staff every 3 years. According to NHCC, there are currently about 100 homemaker/home health aide providers which have chosen to be part of this accreditation process, with about 40 additional agencies in the pipeline. Most of the agencies covered by this accreditation process provide only homemaker/home health aide services, with a few also providing home health care services.¹⁴

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) also has an accreditation program for a variety of organizations providing home care services.¹⁵ JCAHO accredits four different kinds of home care providers: home health agencies; durable medical equipment companies providing equipment in the home; infusion therapy companies providing a variety of intravenous services; and private duty home care agencies that provide nursing services as well as homemaker, home health aide, and companion services. JCAHO has accredited about 500 agencies and organizations. Accreditation standards for these organizations vary according to the particular service being provided by the organization. Accreditation surveys are announced in advance and include on-site observations of the organization as well as visits to clients' homes. If it is found to be in substantial compliance with Joint Commission standards, an organization is awarded accreditation for 3 years and not resurveyed until the end of its accreditation cycle (although JCAHO may conduct interim surveys for organizations accredited with certain kinds of problems).

The National League for Nursing (NLN) also accredits a variety of home care programs, including home health agencies, private duty home care agen-

¹⁴ This information was obtained in a telephone conversation with NHCC on Aug. 18, 1989.

¹⁵ This information was obtained in a telephone conversation with JCAHO on Aug. 21, 1989, and from JCAHO's 1988 *Standards for the Accreditation of Home Care*.

¹³ Department of Health and Human Services, Review of State Quality, *Assurance Programs for Home Care*, III-1 through III-7.

cies, public health nursing programs (components of local departments of health), community nursing centers, infusion therapy companies, home medical equipment companies, and home pharmacy services.¹⁶ NLN has accredited about 200 programs. Accreditation standards include certain core standards that are applied to all agencies, as well as program specific standards that are applied to particular services. Surveys to determine compliance with standards include both on-site observation of the agency and visits to the homes of clients. For those agencies found to meet NLN standards, accreditation lasts for 3 years. NLN is currently implementing a new survey process for accreditation. During the 3-year accreditation cycle for a particular agency, NLN will conduct unannounced annual site visits. These site visits will include visits to the home and a survey of client satisfaction.

Adult Day Care

Generally, adult day care programs provide a variety of health and social services to persons with physical, emotional, or mental impairments in a group setting on a part-time basis. There is no federally recognized definition of day care.¹⁷ Services which may be included in a day care program are: assessment of client needs; health monitoring; skilled nursing services; physical, occupational, and speech therapies; personal care; nutritional services; counseling; and transportation. Depending upon the needs of participants, care provided may range from active rehabilitation in a post-acute phase of an illness to the provision of one or more health or health-related social services.

It is estimated that there may be between 2,100–2,600 adult day care programs.¹⁸ Programs are supported primarily through the Medicaid, SSBG, and Older Americans Act programs, and through State and private funds. States have great flexibility in defining standards, and monitoring and assuring compliance with standards.

A distinction is made between a health model and a social model for adult day care programs. Generally

the combination of health and social services offered, the kinds of participants served, and the kinds and number of staff involved in the program distinguish models from one another. Standards applicable to the varying models of day care may vary, depending on the model of day care funded. For example, a health-oriented day care program may be subject to specific nurse staffing standards, as compared to a social services model which would emphasize social services staff.

Federal Requirements

Medicaid—States may cover adult day care services under two provisions of the Medicaid program: as an optional service under their State Medicaid plans (under the clinic services and rehabilitative services options) or as part of their 2176 home and community-based waiver programs. In addition, to the extent that other covered Medicaid services are provided in an adult day care setting (e.g., physician services), they may be covered under the program. In general, Medicaid allows States to follow their own procedures for certifying noninstitutional providers. Medicaid regulations contain general requirements that each State Medicaid plan include a description of the methods and standards used to assure that covered services are of high quality. There are no Federal standards or monitoring or enforcement mechanisms specifically applicable to adult day care centers funded under Medicaid.

Adult day care programs funded under the 2176 waiver authority must meet the requirements described above in the discussion of quality assurance requirements for 2176 services.

Other Federal Programs—In FY 1988, 23 States planned to use SSBG funds to support adult day care services.¹⁹ There are no Federal requirements related to standards for adult day care services provided with SSBG funds.

State agencies on aging may use funds authorized under title III of the Older Americans Act funds to support adult day care services. As in the case with home care services provided under the Older Americans Act discussed above, there are no specific Federal quality assurance requirements with respect to adult day care programs funded under the Older Americans Act. Title III law and regulations contain general requirements that State and area agencies are

¹⁶ This information was obtained in a telephone conversation with NLN on Aug. 22, 1989.

¹⁷ In 1984, as part of a project to develop national standards for adult day care, the National Institute on Adult Daycare (NIAD) of the National Council on Aging (NCOA) defined the service in part as follows: Adult day care is a community-based group program designed to meet the needs of functionally impaired adults through an individual plan of care. It is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective setting during any part of a day but less than 24-hour care.

¹⁸ This is an unofficial estimate based on data being obtained by researchers at the University of California, San Francisco under contract with HCFA.

¹⁹ This information was obtained in a telephone conversation with the Office of Human Development Services staff.

to conduct periodic evaluation of services provided under State and area plans on aging.

State Requirements

Very little evaluative data are available on the extent to which States have established standards and procedures for assuring the quality of adult day care. Two studies have collected information on standard setting. According to a recent survey of State regulation of adult day care (specifically focusing on day care centers in the health model) by the Intergovernmental Health Policy Project, 35 States have standards for day care facilities.²⁰ The survey reviewed whether States had requirements for licensure of facilities, certification of facilities, or standards used to assess the eligibility of centers for particular sources of funding. It found that 22 States had licensure requirements. In addition, 13 States used standards to certify facilities or to otherwise determine a facility's eligibility for a particular funding source.²¹ However, the number and type of standards used by States varied significantly. For example, of the 22 States which had licensure requirements, nine States had optional or unspecified requirements for regular on-site nursing supervision of participants. While most States specified minimum staff/participant ratios, some specified only that the program have "sufficient staff."

The study indicated that licensure or certification may not assure uniformity of day care services in a State; for example, some States may license or certify only the social day care model while others may license or certify both the social and health care model. While the study did not go into depth about monitoring and enforcement of standards, it concluded that oversight of standards was minimal.

A survey of day care facilities completed by NIAD in 1986 reported on the extent to which facilities were either licensed or certified.²² Of a total number of about 800 responses by facilities to a question about licensing, 57 percent of the facilities (459) indicated that they had at least one license. Of about 670 responses as to certification of centers, about half were not certified.

²⁰ Intergovernmental Health Policy Project, *State Regulation of Adult Day Health Care Facilities* (May 1989).

²¹ Seven States used standards for certification of facilities for reimbursement, usually Medicaid. Another six States were found to use standards to determine eligibility for particular funding sources, but these standards were generally less stringent than certification standards. In addition, certification procedures generally included on-site compliance review.

²² NIAD, *Adult Day Care in America: Summary of a National Survey* (October 1986). Licensure usually signifies that a facility has met a certain defined set of standards. Certification signifies that a facility meets certain standards making it eligible for reimbursement of specific program funds.

The Medicare Catastrophic Coverage Act of 1988 requires HHS to conduct a study of adult day health services. Among other things, the study is to collect information on the characteristics of entities providing services and licensure, certification, and other quality standards that are applied to providers. The Secretary of HHS is required to make recommendations concerning appropriate standards for coverage of adult day care services under Medicare, including qualifications of providers. The study is to be completed by July 1, 1990.

Voluntary Organizations

Adult day programs have experienced tremendous growth since the program concept was the subject of research and demonstration initiatives supported by DHHS in the early 1970s. In order to provide assistance to States in this developing field, the National Institute on Adult Day Care (NIAD) of the National Council on Aging (NCOA) published national standards for adult day care in 1984. The purpose of the standards was to serve as guidelines for the implementation of quality centers and to provide national direction for policy formation related to centers. The standards address issues related to target population, administrative structure and organization, staffing, essential services, facility, and evaluation.²³

These standards are used as a model for the development and implementation of day care programs. NIAD does not currently accredit any individual day care programs. There has been some interest on the part of day care advocates to stimulate a national accreditation process.

Board and Care Facilities

Board and care is a generic term referring to a wide range of community-based nonmedical residential care facilities that provide room, board, and protective oversight to the elderly and disabled. Various terms may be used to describe this service, including domiciliary homes, adult care homes, foster care homes, and personal care homes. In addition to room and board, residents of such homes may receive assistance with activities of daily living as well as other assistance, such as supervision of medication and money management.

²³ National Council on the Aging, Inc., National Institute on Adult Daycare, *Standards for Adult Day Care* (fall 1984).

A recent review of board and care by the General Accounting Office (GAO) indicated that the total number of board and care homes is unknown.²⁴ A 1987 survey of board and care indicated that there were about 41,000 licensed homes with about 563,000 beds. GAO indicated that this represents an undercount since there is an unknown number of unlicensed facilities. An analysis completed by the House Select Committee on Aging estimated that number of unlicensed homes may be over 28,000. This analysis estimated that licensed and unlicensed homes serve over 1 million elderly and disabled persons.²⁵

Board and care homes receive funding for care they provide directly from residents who pay operators with income received through social security, Federal and State payments under SSI program, and other income. However, the GAO analysis indicated that the board and home care population includes many who rely primarily on SSI income to pay for their care. A 1983 survey of 2,933 residents of licensed and unlicensed board and care homes in 7 States indicated that mentally retarded and mentally ill residents were more likely to receive SSI than elderly residents. Elderly persons were more likely than the other groups to receive social security income.²⁶

Assuring quality of care in board and care settings has proven difficult in part due to the lack of national standards and ineffective monitoring of facilities. Despite oversight responsibilities cited in Federal law discussed below, regulatory responsibility resides with States. GAO and the House Select Committee on Aging have cited serious problems in quality of care and resident abuse.²⁷

Federal Requirements

Supplemental Security Income Program—The only major Federal requirement related to quality assurance for board and care facilities is found under SSI program requirements. Section 1616(e) of the Social Security Act (otherwise referred to as the Keys amendment after its author) requires States to establish, maintain, and enforce standards for group living arrangements in which a significant number of SSI recipients reside. Standards must be appropriate to the needs of recipients and the type of facility and cover areas such as admission policies, safety, sanitation, and

protection of civil rights. The State is further required to annually certify to the Secretary of HHS compliance with these provisions. The law stipulates that SSI payments to individuals will be reduced if board and care facilities are not approved according to the State standards.

Many have concluded that the Keys amendment is unenforceable. For example, neither the law nor Federal regulations define what is a "significant number" of SSI recipients. In addition, the sanction the law imposes for noncompliance by States penalizes SSI recipients. The sanction is not directed at penalizing States who do not approve facilities according to established standards, or board and care operators who may be offering substandard care.

GAO has indicated that HHS review of State compliance with the Keys amendment is minimal. The Office of Human Development Services (OHDS), which has been given responsibility for oversight of State compliance, commits one-eighth of one person's time to reviewing State certifications and summaries of standards.²⁸

Older Americans Act—As discussed earlier under Federal nursing home requirements, the Older Americans Act requires that the ombudsman program investigate and resolve complaints of residents of board and care facilities and other adult care homes. There is little evaluative data on the impact of the ombudsman program on the board and care industry.

GAO reported that AoA's role in the ombudsman oversight of board and care is limited and that AoA allows great discretion to States in implementation of the program. The 1987 amendments to the Older Americans Act required that the Commissioner on Aging conduct a study of the impact of the ombudsman program on board and care facilities and other similar adult care homes. The study is to be submitted to Congress by December 31, 1989.

State Requirements

The most common means by which States oversee care provided in board and care facilities are licensing requirements and oversight responsibilities of the State ombudsman program authorized under the Older Americans Act. Both the GAO report and the House Select Committee on Aging analysis indicated that neither of these have been effective in assuring quality of care and preventing abuse of residents.

²⁴ General Accounting Office, *Board and Care. Insufficient Assurances That Residents' Needs Are Identified and Met* (GAO/HRD, February 1989). (Hereafter cited as *Board and Care*.)

²⁵ U.S. Congress, House Select Committee on Aging, *Board and Care Homes in America: A National Tragedy*, House Report No. 101-711, 101st Cong., 1st sess., March 1989, 9. (Hereafter cited as *Board and Care Homes in America*.)

²⁶ *Board and Care*, 15.

²⁷ See footnotes 24 and 25 for references.

²⁸ *Board and Care*, 35.

The House Select Committee on Aging survey found that all but 10 States have licensing requirements which vary significantly by State. Enforcement of licensing requirements also varies greatly. The large estimated number of unlicensed homes indicates that a licensure requirement alone is insufficient in order to assure quality and that adequate staff to enforce licensure requirements is also necessary.

State licensure requirements generally establish criteria for the minimum number of residents per home, ranging from 1 to 21 residents, and specify the types of services to be provided residents. GAO indicated in its review of six State licensure policies that most requirements focus on physical plant; only one State included social evaluations through resident interviews. GAO further indicated that States have difficulty in imposing sanctions against poor quality homes. Sanctions available in the six States were authority to close homes or suspend licenses. Three States imposed intermediate sanctions, such as fines or receivership. Two States indicated that imposition of fines was not an effective deterrent to substandard care.

Board and care facilities were included under the oversight responsibilities of State ombudsman programs in the 1981 amendments to the Older Americans Act. State agencies on aging are required to assure that ombudsmen have access to facilities and patient records. An analysis of 38 State statutes pertaining to the ombudsman program completed by the National Association of State Units on Aging (NASUA) in 1987 found 24 statutes specifically authorized ombudsman access to board and care facilities or personal care homes.²⁹ This number is slightly lower than the number of States reporting that they had oversight authority for such facilities in the House Select Committee on Aging analysis. That

study found that 43 States had oversight over board and care homes.

Because of the large estimated number of licensed and unlicensed homes, it may be difficult for ombudsmen to investigate and resolve complaints from board and care residents. The House Select Committee on Aging survey of States indicated that investigation of complaints from board and care residents did not appear to be a priority for ombudsmen. As a national average only about 16 percent of ombudsman efforts were devoted to handling complaints from board and care residents. Only two States indicated that the ombudsman program has staff who work exclusively on board and care homes. Only 17 State ombudsmen queried indicated that the State system for regulating board and care homes is adequate.³⁰ GAO also concluded that the ombudsman efforts in board and care facilities are limited.

Voluntary Organizations

In 1984 the American Bar Association (ABA), under a grant from OHDS, published recommended standards for board and care homes, *A Model Act Regulating Board and Care Homes: Guidelines for States*. In part, the purpose of the guidelines was to develop a statutory scheme for licensing board and care homes to ensure a safe and decent environment for the elderly and disabled and to establish standards for regulating such homes. Among other things, the model act covers the following items: definition of board and care homes; recommended size limitations; delegation of rulemaking, adjudicative, and investigative authorities; resident plan of care requirements; admission policies; resident rights; staffing and physical environment requirements; licensure requirements; procedures for inspections and investigation of homes; and sanctions and penalties.

²⁹ National Association of State Units on Aging, 5.

³⁰ *Board and Care Homes in America*, 146, 160, and 179.

DUE PROCESS: REVIEW AND APPEAL PROCEDURES IN LONG-TERM CARE

Jane Handler Yurow *

EXECUTIVE SUMMARY

The United States Constitution requires federally financed or administered benefit programs (benefit programs) to provide for review and appeal of decisions adverse to applicants, beneficiaries and claimants (beneficiaries), in accordance with constitutional standards of due process of law.

A new federal long-term care benefit program (long-term care program) will need to include review and appeal procedures integral to and appropriate for the goals of the program itself.

The review and appeal procedures in existing benefit programs demonstrate the complexity of the process and the difficulties in integrating program considerations with achieving due process goals. Medicare, Social Security Disability Insurance and Supplemental Security Income, and Department of Veterans Affairs Disability Compensation and Pension programs provide a wealth of experience on which policymakers can draw in designing a review and appeal process for a long-term program.

Although many policy considerations are common to benefit programs generally, a long-term care program will also have particular characteristics that will influence the development of its review and appeal procedures. These include:

- focus on chronic as well as acute care problems
- emphasis on provision of social and custodial services rather than medical care
- involvement of the family or other informal caretakers in decisionmaking about appropriate care

- need for frequent reassessment of care plans to respond to changing service needs
- the central role of the case manager, with loyalties to both the beneficiary and the benefit program, in developing and monitoring care plans

Review and appeal procedures of existing benefit programs are too complex to be understood by most individuals. A long-term care program might establish simpler procedures. To the extent possible, these should be readily understandable to physically frail, mentally ill or cognitively impaired individuals or their caretakers.

Specific lessons that can be drawn from the experience of existing benefit programs and their implications for a long-term care program follow.

Type of benefit, sources of financing and structure of administration of benefit programs.—Initial determinations as to eligibility for disability benefits with periodic payments over the long term are more amenable to due process review than determinations as to payment for acute care often made quickly and based on inadequate information. A long-term care program, addressing both acute and chronic care needs in the same individual, often at the same time, requires procedures sensitive to these differing program considerations.

Benefit programs may have differing due process requirements depending on their source of financing and type of administration—federal, federal-state, or federal-private. Decisions made about the financing and administration of the long-term care program itself, will influence the design of its review and appeal process.

* Prepared for the United States Bipartisan Commission on Comprehensive Health Care (The Pepper Commission), March 22, 1990.

Cost containment and placing risk.—Benefit programs chronically strapped for funds sometimes resort to cost-cutting shortcuts in their review and appeal procedures. Some of these may be unconstitutional, particularly if they result in depriving beneficiaries of access to these procedures.

In a long-term care program, where beneficiaries develop relationships of trust with service providers, cost containment measures may jeopardize these relationships. Where providers bear the risk for providing services not covered by a benefit program, tension may develop between the provider and the beneficiary. This might be mitigated if the benefit program could make coverage decisions prior to the provision of services.

Representation by lawyers or lay advocates.—Representation substantially increases the likelihood that beneficiaries will prevail in review and appeal proceedings. Currently, the supply of trained beneficiary representatives is far short of the demand for their services.

Because of the greatly increased number of public benefit recipients engendered by a long-term care program, policymakers need to consider supporting programs to train and compensate legal and lay advocates to represent beneficiaries both in existing and new benefit programs. The use of trained lay advocates supervised by attorneys may be particularly effective.

Adequate notice and timely decisions.—Inadequate information in notices limits beneficiaries in planning their reviews and appeals. Extended time periods for decisionmaking often deprive frail, low-income beneficiaries of basic resources. Benefit programs have been criticized on both counts. A long-term care program needs to insure adequate staff and resources for processing claims, reviews and appeals expeditiously. The development of adequate notice language is usually evolutionary in a benefit program, but program administrators should be sensitive to its importance.

Access to information critical to decisions.—Benefit programs generally communicate significant information relating to claims decisions through limited circulation manuals, directives or informal contacts rather than publishing them in the Federal Register. This restricts beneficiaries' access to information that may be critical to effective challenges of claims-related decisions.

In a long-term care program, many decisions will involve subtle changes in care plans, often based on

informal discussions with beneficiaries or caretakers. Administrators of this type of program have as much responsibility as in more formally structured benefit programs to provide protesting beneficiaries with access to critical information.

Decisions based on an adequate record.—Benefit programs not providing the resources or trained staff necessary to develop claims files containing all relevant evidence are countenancing inadequate determinations of initial claims. This results in: unfair decisions that, for various reasons, are never appealed; delays in the review and appeal process in order to collect information that should already be in the claims file; or requiring appellate level adjudicators to perform functions more appropriately performed by others.

In a long-term care program, most claims information will not be medical, and so conditions may be less amenable to technical description or precise measurement than in existing benefit programs. Long-term care programs will need to make specific provisions, including setting standards, for developing and monitoring adequate claims files.

Verbal statements in front of decisionmaker.—Experience of benefit programs indicates that beneficiaries receiving some sort of face-to-face meeting with decisionmakers are significantly more likely to prevail than those receiving paper-based determinations. But most benefit programs discourage face-to-face meetings with decisionmakers until a late stage of the review and appeal process.

The face-to-face hearing is likely to be particularly important in a long-term care program where beneficiaries and caretakers will participate with case managers—the initial decisionmakers—in developing, monitoring and modifying care plans. Telephone hearings may not be an effective alternative to face-to-face reviews for the long-term care population because many of these individuals suffer from hearing loss or confusion.

Hearing prior to denial or termination of benefit.—When termination of benefits or services critical to life are at issue, beneficiaries may be entitled to some sort of prior review and appeal. Beneficiaries of a long-term care program may be poor or mentally or physically vulnerable. Premature deprivation of support, particularly for those beneficiaries living in the community, could be devastating. Because changes in a care plan are more likely in a long-term care program than total termination from the program, it is

particularly important to designate the types of changes that require prior review.

Decision by an impartial individual or panel.—Decisionmaking independent of benefit program influence is a critical goal of due process. Existing benefit programs have sometimes had difficulty in achieving this. Because the initial claims-related decisions in a long-term care program are likely to be made by case managers, directly or indirectly funded by, and responsible to, the benefit program, long-term care legislation needs to establish objective procedures for review and appeal of these initial decisions.

ORGANIZATION OF REPORT

This report is organized as follows:

- A discussion of the constitutional and legal requirements of due process of law in review and appeal of claims made by applicants or beneficiaries of federal social insurance or entitlement programs (I–III)
- Brief descriptions of the claims review and appeal procedures of specific federally financed health care or disability benefit programs—Medicare, Social Security, and Department of Veterans Affairs (IV)
- A discussion of basic program considerations that have influenced the design of review and appeal procedures in benefit programs, and of the particular characteristics of a long-term care program that need to be addressed in developing appropriate review and appeal procedures (V)
- An analysis of the experiences of Medicare, Social Security, and the Department of Veterans Affairs in developing and administering review and appeal procedures intended to comply with constitutional due process (VI)
- A summary of significant lessons learned from the experiences of these programs, and the implications of these lessons for a new, federally financed long-term care program (VII)
- A review of selected programs providing advocacy, assistance, information, or other services that assist beneficiaries of federally funded benefit programs effectively to assert their due process rights, with a view toward identifying ways to deliver similar services to beneficiaries of a new federally financed long-term care program (VIII)

TABLE OF ACRONYMS

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| ADL | — | Activity of Daily Living |
| ALJ | — | Administrative Law Judge |
| BVA | — | Board of Veterans Appeals |
| CPS | — | Compensation and Pension Service |
| DDS | — | Disability Determination Service |
| DI | — | Disability Insurance |
| DRG | — | Diagnosis Related Group |
| DVA | — | Department of Veterans Affairs |
| HHA | — | Home Health Agency |
| HHS | — | Department of Health and Human Services |
| HMO | — | Health Maintenance Organization |
| NDG | — | Network Design Group |
| PRO | — | Peer Review Organization |
| SSA | — | Social Security Administration |
| SNF | — | Skilled Nursing Facility |
| SSI | — | Supplemental Security Income |

INTRODUCTION

Legislative proposals for establishing a federal long-term care benefit program (long-term care program) are likely to include procedures for review and appeal when individuals are denied benefits to which they consider themselves entitled. The design of an effective review and appeal process for this program will be an additional challenge to policymakers.

Existing Benefit Programs

The experiences of federally financed or administered health care related programs (benefit programs) with review and appeal procedures provide significant lessons for the design and implementation of similar procedures for a new long-term care program. This report focuses on review and appeal procedures available to applicants and beneficiaries (beneficiaries), except when the interests of service providers and beneficiaries cannot be separated. Although the analysis often focuses on certain difficulties benefit programs may have in meeting constitutional due process expectations, it is not intended as a criticism of the review and appeal process in these programs.

The purpose of the report is to understand the problems existing programs have encountered in providing due process in reviews and appeals, in order to use the experiences of these programs as guidance to policymakers in designing similar procedures for a

new federal long-term care benefit program. Several types of benefit program determinations could be adverse to a beneficiary's interest. In describing the practices of existing benefit programs, this report focuses on two of these:

- The initial determination that a beneficiary does not have a medical condition that qualifies her/him for program benefits or payment for a specific course of treatment or level of care;
- The decision to terminate a beneficiary from the program or to cease payment for a course of treatment or level of care because her/his medical condition no longer qualifies her/him for benefit or payment.

Most beneficiary appeals involve these questions.¹

Particular Characteristics of a Long-Term Care Program

The application to a long-term care program of review and appeal procedures used in existing benefit programs will require imagination and flexibility. Characteristics of a long-term care program that make it distinct from these programs are its focus on:

- chronic as well as acute care needs
- custodial and social services rather than medical care
- involvement of family or other informal caretakers in decisionmaking about appropriate care
- the need for frequent reassessment of care plans to respond to changing service needs
- the central role of the case manager, with loyalties to both the beneficiary and the benefit program, in developing and monitoring care plans

WHY WOULD A NEW FEDERAL LONG-TERM CARE PROGRAM BE REQUIRED TO PROVIDE REVIEW AND APPEAL PROCEDURES FOR BENEFICIARIES AND APPLICANTS?

The U.S. Constitution (Amendments 5 and 14) prohibits the government from taking a person's life, liberty or property without following certain legal procedures designed to ensure that the government's action is fair and impartial. These procedures are in-

tended to protect citizens from arbitrary government conduct. The nature of and requirements for these legal procedures, called procedural due process, have evolved through litigation and legislation.

Federally financed or administered programs providing benefits or other payments to individual beneficiaries or claimants are subject to constitutional due process. Statutory and regulatory provisions in these programs establish review and appeal procedures intended to meet constitutional standards.

For a new long-term care program the issue is not whether to adopt review and appeal procedures but what sort of procedures are appropriate. The development of appropriate review and appeal procedures is integrally related to the design and operation of the long-term care program itself.

On the one hand, beneficiaries are more likely to perceive a benefit program's review and appeal process as fair if they consider the administration of the program itself to be fair. A program that raises false expectations among beneficiaries and providers of service, or communicates its goals and limitations ineffectively, may cause needless confusion among beneficiaries as to their entitlements. The result could be increased resort to the review and appeal process for clarification of entitlements. This, in turn, could raise the cost of program administration significantly.

On the other hand, the effectiveness of the review and appeal process could have major implications for the ongoing success of the benefit program. If beneficiaries do not consider the decisions on review to be fair, they might harbor mistrust for the program, providers or the federal government more generally. Beneficiary mistrust can become costly to a program that exhibits a pattern of decisionmaking perceived as unfair.

If significant numbers of beneficiaries complain to their legislators that a program's claims, review or appeal determinations are unfair, Congress is likely to investigate these practices. Also, groups of beneficiaries with similar complaints may institute class actions against the program in federal court in an effort to force change in its practices. The financial and public relations cost to the program of these actions could be substantial.

¹ Eleanor Kinney, "The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint," *The Administrative Law Journal*, 1, (1) (1987): 69.

WHAT ARE THE COMPONENTS OF A REVIEW AND APPEAL PROCEDURE THAT MEETS DUE PROCESS REQUIREMENTS?

All benefit program review and appeal procedures must meet certain minimal legal requirements but not necessarily in the same manner or degree. The goal of a due process review is to ensure that the person who has been, or may be, denied a benefit has "the opportunity to be heard" ² regarding his reasons as to why he should not have been so denied. But the concept of a due process review is complicated.

Basic Components

Certain basic components are considered essential to a due process determination on the issues of denial or termination of eligibility from a benefit program or of benefits under a program. The formulation of a prominent administrative law scholar includes:

- timely and adequate notice to the beneficiary of denial, reasons for denial, the right to review or hearing and the issues to be presented
- opportunity for the beneficiary to make an oral statement or argument, and to present evidence and witnesses
- opportunity for the beneficiary to confront and cross-examine witnesses
- full disclosure by the government of all relevant evidence
- right of beneficiary to be represented by counsel and for compensation of counsel, if indigent
- right to a decision based on the record
- a statement of findings of fact and reasons for decision
- an impartial hearing officer.³

There are a variety of legally permissible approaches to achieving due process in administrative procedures. The variations often have a historical or political basis, or are the outgrowth of differing mechanisms for financing or administering the programs. Where the beneficiary's interest in obtaining certain due process protections conflicts with the public interest in limiting these protections, a balancing of interests is required. The factors to be considered in balancing private versus public interests are:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.⁴

Due Process in Practice

Welfare programs financed from general revenues may be required to observe stricter due process standards than social insurance programs because of the total destitution of welfare recipients.⁵ Where, however, vulnerable populations, such as low income, ill, elderly individuals, are permanently denied payment by a federally supported insurance program for medical expenses to which they consider themselves entitled, some courts have said that government must provide them with substantial due process.⁶ From time to time, Congress has enacted legislation designed to correct the perceived systemic failure of certain benefit programs to provide beneficiaries with sufficient procedural due process. Two examples are:

- the requirement that the Department of Health and Human Services offer beneficiaries an opportunity for a hearing before an administrative law judge on appeal from denials of Medicare claims by private insurance carriers;⁷ and
- the creation of an independent Court of Veterans Appeals to review final denials of disability benefits by the Board of Veterans Appeals in the Department of Veterans Affairs.⁸

WHAT ARE THE REVIEW AND APPEAL PROCEDURES OF EXISTING FEDERALLY FINANCED OR ADMINISTERED HEALTH-RELATED BENEFIT PROGRAMS?

This section describes briefly the review and appeal procedures of certain benefit programs. These are:

- Medicare—hospital insurance, supplementary medical insurance, and prepaid health care;

⁴ *Mathews v. Eldridge*, 424 U.S. 319, 335 (1975).

⁵ *Mathews v. Eldridge* 424 U.S. 319 (1975), *Goldberg v. Kelly*, 397 U.S. 259 (1969).

⁶ *Gray Panthers v. Schweiker*, 652 F.2d 146 (1981); *Fox v. Bowen*, 656 F.Supp. 1236 (DCT, 1980); *Martinez v. Bowen*, 655 F.Supp. 95 (DNM, 1986).

⁷ 42 U.S.C., Sec. 1395ff.

⁸ Veterans Judicial Review Act, P.L. No. 100-687.

² *Grannis v. Ordean*, 234 U.S. 385, 394 (1914).

³ See Kenneth Culp Davis, *Administrative Law of the '70's* (Rochester, NY: The Lawyers Coop Publishing Co., 1976): 242.

- Social Security Administration (SSA)—disability insurance and supplementary security income;
- Department of Veterans Affairs (DVA)—disability allowance and disability pension.

The two SSA programs use the same review and appeal procedure, as do the two DVA programs. Each of the three Medicare programs uses a different set of procedures. All of the benefit programs provide similar stages for review and appeal. These include: an initial determination by the benefit program or its designee; a reconsideration by the program or its designee; an appeal to an administrative body or bodies within the agency not involved with ongoing benefit program determinations; and a further appeal to a federal court. The type of mechanism used at each stage varies considerably among programs, as do many program practices.

This section also identifies the federal criteria for review and appeal procedures that states must meet in order to receive federal Medicaid funding. The Medicaid program is not included, however, in the more detailed analysis of program practices in other sections of this report.

Finally, this section describes review and appeal procedures of two private insurance companies offering group long-term care insurance with a managed care component. Private companies have no constitutional obligation to provide due process review and appeal procedures. Any legal requirements would be based in state law. The private insurance company programs are:

- ORS LTC Aetna Long-Term Care
- The Travelers Long Term Care Plan with Case Management

Medicare

Medicare⁹ is a national health insurance program for persons 65 years and over and certain categories of disabled persons. Medicare is administered by the Department of Health and Human Services (HHS) through the Health Care Financing Administration (HCFA).

Medicare delegates a substantial portion of both program administration and review functions to various private sector organizations. These include insurance companies acting either as the recipients of hospital, nursing home or home care claims (fiscal

intermediaries) for the Part A compulsory participation program or as the initial claims processors (carriers) for the Part B voluntary insurance program. In addition, organizations of physicians, Peer Review Organizations (PROs) and Health Maintenance Organizations (HMOs) are engaged in processing and reviewing claims as part of the Medicare program.

Medicare Hospital Insurance (Part A)—This program is financed by contributions of employees and employers to Social Security earmarked for Medicare. It functions like an insurance program, making payments for inpatient hospital care, skilled nursing facility care, home health care, and hospice care. In FY 1989, 29.4 million aged and 3.2 million disabled persons were protected under part A. Of these, 6.7 million older persons and .8 million disabled persons actually received reimbursed services.¹⁰ Medicare Part A has a different review and appeal procedure for determinations about medical necessity and appropriateness of care in hospitals than for all other claims. These review procedures are particularly complicated and cannot readily be described in summary form.¹¹ Within the category of hospital claims, pre-admission screening claims are handled somewhat differently than in-patient claims. The bulk of other claims involve services of a skilled nursing facility (SNF) or a home health agency (HHA).

Descriptions of review and appeal procedures in these three situations follows.

Hospital Claims Requiring Medical Determinations for Pre-Admission Screening—Any decision should be totally based on the medical needs of the beneficiary.

In the case of elective or nonemergency surgery the hospital may notify the beneficiary that in the hospital's opinion Medicare will not pay for the surgery.

The beneficiary may request a written statement of the hospital's opinion.

The beneficiary should notify the PRO, a private organization of physicians that has a contract with HCFA, as soon as she/he receives notice. The PRO has three working days to respond to request.

If the PRO agrees that admission will not be covered, the PRO's decision is a Medicare denial and

¹⁰ House Committee on Ways and Means, *Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*, 101st Cong., 1st Sess., 1989, Committee Print 4, 127.

¹¹ See AARP, *Medicare's Prospective Payment System. Knowing Your Rights* (Washington D.C.: Revised 1988), for an excellent description of these procedures.

⁹ Social Security Act, Title XVIII, 42 U.S.C., Sec. 1395, *et seq.*, and Title XI, 42 U.S.C., Sec. 1320c, *et seq.*

its notice must advise the beneficiary of right to reconsideration.

The PRO may notify the beneficiary that Medicare will not pay for elective surgery. This notice must contain: reasons for denial, right to expedited reconsideration, how to request reconsideration, and that beneficiary can submit additional evidence.

The beneficiary must request reconsideration within three calendar days of receiving notice.

If, on reconsideration, the PRO denies or partially denies a claim, the notice must state: the basis for the decision, and description of further appeal rights. No face-to-face hearing is required.

Hospital Claims Requiring Medical Determinations For Hospital Inpatient Beneficiaries—When the beneficiary enters the hospital, the hospital must give her/him a statement of rights to review and appeal under Medicare.

If the hospital or physician determines that the beneficiary's stay is no longer medically necessary or that the beneficiary requires a different level of care, the hospital or physician informs the beneficiary that there will be no Medicare coverage after three days.

If the beneficiary is informed orally, disagrees with this decision and remains in the hospital, she/he may ask the hospital for written notice of its decision.

If the doctor has agreed with the hospital the written notification must come from the hospital. The beneficiary may request the PRO, to review the hospital's decision. If the PRO agrees with the hospital, the PRO's notice to the beneficiary is a Medicare notice of noncoverage or initial denial determination.

Upon receiving notice, the beneficiary has until noon of the next working day to request PRO reconsideration.

The PRO must consider the case within one workday after getting a request. The PRO must solicit the beneficiary's views and examine the medical record. No face-to-face hearing is required.

The PRO must send the beneficiary, doctor and hospital its decision within the next full workday after receiving the request for review and the hospital's records. One day after receiving the initial denial determination, the beneficiary may be charged for the remaining hospital stay.

Decision must include notice of appeal rights.

If doctor has disagreed with the hospital the hospital must tell the beneficiary it is requesting a decision from the PRO which must directly inquire of the beneficiary about his condition prior to making a decision.

If the PRO agrees with the hospital, both the PRO and the hospital must send the beneficiary a Medicare notice of noncoverage.

The beneficiary may request an expedited reconsideration from the PRO by calling the PRO as quickly as possible.

The PRO has three workdays from the date of sending the beneficiary the notice of noncoverage to make a reconsideration decision. No face-to-face hearing is required. If the PRO denies the claim, the beneficiary may be charged for the remaining days of her/his hospital stay.

The decision must include notice of appeal rights.

In both of the above situations if the amount in controversy is at least \$200, the beneficiary may request a *de novo* face-to-face hearing before an SSA Administrative Law Judge (ALJ). The beneficiary may be represented.

If the claim is denied, the SSA Appeal Councils may review the claim at the beneficiary's request or on its own initiative, and either decide or dismiss the case.

After Appeals Council action, any party may request a hearing in U.S. District Court, if the amount in issue is at least \$2,000. The parties may be represented.

Skilled Nursing Facility and Home Health Agency Claims—For all claims other than hospital claims requiring medical determinations if the service provider decides that the service is not medically necessary or that skilled care is inappropriate for the beneficiary, either prior to providing service initially or before terminating an ongoing service (the more usual situation) the service provider (SNF or HHA) must:

- notify the beneficiary in writing that it does not believe that the service or confinement is covered by Medicare;

- inform the beneficiary that she/he can request a Medicare determination of whether or not the service or confinement is covered;
- submit the claim to the insurance company serving as fiscal intermediary on behalf of the beneficiary stating that it believes that Medicare will not cover the confinement or service (a no-payment claim). (SNFs may not bill a beneficiary prior to the fiscal intermediary's initial decision; HHAs may do so.)

If the service provider decides that Medicare is likely to pay the claim, it must submit a claim for payment on behalf of the beneficiary to the fiscal intermediary to determine whether or not the service or confinement is covered by Medicare. If the fiscal intermediary denies the claim, it must send a denial notice to the beneficiary indicating her/his right to request reconsideration by the fiscal intermediary.

If the reconsideration is a denial, the fiscal intermediary must notify the beneficiary of the decision in writing indicating further appeal rights. A face-to-face hearing is not required.

If the amount in controversy is at least \$100, the beneficiary may request a face-to-face *de novo* hearing before an SSA ALJ.

The beneficiary may be represented.

The beneficiary may request a review by the SSA Appeals Council or the Council may review the case on its own initiative. This generally is an on-the-record review.

After action by Appeals Council, all parties may request a hearing in the U.S. District Court, if the amount in controversy is at least \$1,000. The parties may be represented.

In a recent 24 to 36 month period, there were 6,655,505 denials of continued hospital care reviewed by PROs. Four percent or 278,294 of these reviews resulted in denial of coverage. The PROs reconsidered 33 percent of the denials, or 91,268 cases, and reversed 44 percent of these, or 40,016.¹²

In FY 89, there were 75,620,079 claims filed for Part A Nursing Home and Home Health Care benefits. Of these, 3,882,546 were denied. There were 40,001 reconsiderations of which 47 percent were reversals of initial decisions. ALJ proceedings were

held on 9,010 cases with a reversal rate of 81 percent.¹³

Supplementary Medical Insurance (Part B)—Part B is voluntarily financed from premiums of elderly or disabled individuals or those with end-stage renal disease who are enrolled in the program. In FY 1989, 29.2 million aged and 2.9 million disabled individuals were enrolled in Part B. Over 23.6 million aged and 2.3 million disabled individuals received Part B reimbursed services.¹⁴

The beneficiary submits a claim to an insurance carrier for initial determination. If the carrier denies the claim, it must send a written notice of the denial to the beneficiary stating the reasons for denial and informing the beneficiary of her/his right to have the determination reviewed.

The beneficiary may request a review in writing with specific identification of reasons for appeal, and send the request to the carrier's office or an SSA office.

The review is conducted by the carrier, but by a different employee than the individual making the initial determination. The beneficiary may submit written evidence and contentions of fact or law relative to the claim. The carrier may develop additional information. The review is on the record.

If the carrier denies the claim, it must advise the beneficiary of the right to request a hearing, where the amount in controversy is \$100 or more. It must also provide reasons for the denial.

The beneficiary requests a hearing by the carrier at the carrier's office or an SSA office. If all the parties waive personal appearance at the hearing, the carrier will make a determination based on an on-the-record review.

The carrier must send a notice of hearing prior to the hearing that sets forth time and place, purpose, statement of issues, consequences of the hearing and the beneficiary's rights.

The hearing is *de novo*. The beneficiary may bring witnesses, make statements and present other evidence. The beneficiary may be represented by an attorney or lay representative.

If the carrier denies the claim, it must issue a written decision including a statement of law and regu-

¹² Richard Husk, Director, Office of Peer Review, Health Quality Standards Bureau, Health Care Financing Administration, conversation with author (Baltimore, Md.: November 17, 1989).

¹³ Intermediary Appeals Workload Report to Health Care Financing Administration, December 1989.

¹⁴ Ways and Means, *Background Material*, 127.

lations, specific facts, and explanation of reasons for decision. The notice must inform the beneficiary of further appeal rights.

The beneficiary may request a *de novo* hearing by an SSA ALJ if the value of the claim is \$500 or more.

All appeals are processed through a centralized unit, the Development Center, which prepares the record for the ALJ. Beneficiaries may request either an on-the-record review or a face-to-face hearing.

All determinations are made by designated Part B ALJs. On-the-record determinations are made by a specific ALJ, and based on recommendations of the Development Center staff.

The beneficiary may be represented at the ALJ hearing.

If the claim is denied, the beneficiary may request a review by the Appeals Council of SSA which will either decide or dismiss the case. This is an on-the-record review.

After Appeals Council action, any party may request a hearing in a U.S. District Court, if the amount in controversy is at least \$1,000. The parties may be represented.

There were 410,678,568 Part B claims filed in FY 89, 71,722,184 of which were denied. Of 6,075,507 reviews of initial denials, 57 percent were reversed. Of 66,802 carrier fair hearings completed, 56 percent resulted in reversals. The ALJ made decisions in 436 cases, 40 percent of which were reversals of fair hearing denials.¹⁵

Medicare Health Maintenance Organizations (HMOs)—HMOs provide comprehensive medical services to subscribers. Their mechanisms for assessing need and providing health services offer a model for service delivery that is closer to long-term care than any other type of benefit program. HMOs require subscribers to pay a flat amount in advance of service, generally a monthly fee. HMOs contracting with Medicare on a risk basis must agree to provide covered services to Medicare beneficiaries for a pre-determined fixed amount per person.¹⁶ This puts the HMOs at risk of financial loss if costs exceed Medicare payments. In January 1988 there were 130 risk basis HMOs providing services to nearly one million Medicare beneficiaries. Because the HMO pays providers of medical services directly, HCFA maintains

no data on the number of individuals using outpatient services and only limited data on use of inpatient services.

HCFA has contracted out to each HMO the function of reviewing its own decisions as to whether disputed services are covered by the beneficiary's contract with the HMO. HCFA provides minimal guidelines for the design of HMO review and appeal procedures and does not monitor HMO operations in this area. Consequently, HCFA maintains no data on the number of claims denied or the number of initial reviews conducted.

The process by which the HMO determines whether or not a beneficiary may receive services and the review of HMO denials of service vary depending on the policies of the HMO. HMOs are subject to HCFA requirements regarding notice, right to reconsideration, and right to present evidence in person or in writing.

The HMO initial determination and review process described is that of U.S. Health Care.¹⁷

If the HMO denies a request for service, the beneficiary may file a grievance by telephone or in writing with the U.S. Health Care Member Relations Department (MRD). MRD does the initial investigation. If not resolved informally, the beneficiary or MRD may take her/his request to the grievance committee.

The grievance committee has 30 days to act on the request. There are no set procedures; the committee focuses on finding solutions to the problem.

If medical care is an issue in the request for service, the Medical Director of U.S. Health Care sends a letter to the beneficiary's primary physician asking for his decision within a stated period of time. If a specialist is necessary, she/he is asked to make a decision. Although this is not the case in all risk HMOs, at U.S. Health Care the primary physician and specialist are not employees of the HMO. (Although HCFA prefers that decisions are made by physicians or nurses, the HMOs are allowed to decide the credentials of decisionmakers.)

After the physician makes a decision, the U.S. Health Care Grievance Review Board consults with the Medical Director. If the request for service is denied, the HMO sends a letter to the beneficiary stating the decision, reasons for denial, and the right to a reconsideration.

¹⁵ "Carrier Appeals Workload Report to Health Care Financing Administration," December 1989.

¹⁶ 42 U.S.C. Sec. 1395mm.

¹⁷ Mary Lonnergan, U.S. Health Care, telephone conversation with author, November 8, 1989.

If the beneficiary requests a reconsideration, according to HCFA directives the HMO must provide it. The beneficiary may file the request at the HMO or an SSA office.

The reconsideration is to be based on the initial determination and any other evidence submitted by the parties or obtained by the HMO. The beneficiary may request a face-to-face hearing and be represented by an attorney or lay individual.

If the HMO wishes to deny the request for service on reconsideration, the beneficiary's file with indication of how the HMO arrived at its decision must first be sent to HCFA for review. Network Design Group (NDG), a private contractor to HCFA, reviews all files, develops new information, and makes a determination.

If the request for service is denied, the beneficiary may ask for a *de novo* face-to-face hearing or on-the-record review before an SSA ALJ. The beneficiary may be represented.

If the request is denied, the SSA Appeals Council may review it if the beneficiary wishes or on its own initiative, and either decide or dismiss the request. This review is on the record only.

After Appeals Council action, any party may request a hearing in U.S. District Court, if the amount in issue is at least \$1,000. The parties may be represented.

In early 1989, HCFA contracted with NDG to act as its agent in reviewing adverse reconsideration determinations after the HMO has completed its reconsideration review but prior to making a final determination. Of the 1,550 cases that NDG closed, it upheld the HMO decision in 713 and overturned it in 557 cases. An additional 130 were partially upheld. There were 107 requests for an ALJ proceeding.¹⁸

Social Security Administration

The Social Security Administration is responsible for two programs that provide monthly cash benefits to disabled individuals based on established program eligibility criteria—Disability Insurance (DI)¹⁹ and Supplemental Security Income (SSI).²⁰ Although

funding for the two programs comes from different sources, the review and appeal procedures, for the most part, are identical.

SSA has incorporated medical and vocational eligibility criteria into a complicated sequential evaluation process used in making decisions as to initial and continuing eligibility for disability payments. The final step is to determine whether a beneficiary's impairment meets or is equivalent to any of a large number of impairments, called the "medical listings." Beneficiaries whose condition and degree of severity meet or are similar to a listed condition qualify for benefits. If a beneficiary's condition is less severe than the listing, but he has specific vocational limitations that rule out the possibility of working, he is also eligible for either DI or SSI.

Federal law requires that 65 percent of initial determinations of eligibility be reviewed by the Secretary of HHS. In addition, SSA is required to examine every individual on the DI and SSI roles once every three years to determine continuing eligibility for benefits.

Disability Insurance—The DI program provides cash benefits to disabled workers under age 65 and their dependents. Individuals contribute to a Disability Insurance Trust Fund through regular salary deductions that generally are matched by employer contributions. Benefit amounts are related to past earnings of an insured worker. In 1988, 2,830,000 workers and an additional 1,244,000 dependents were on the DI roles.

Supplemental Security Income—The SSI program is a federally administered income assistance program that provides cash benefits to needy aged, blind and disabled individuals who meet established medical eligibility and income criteria. In 1988, 4,434,069 individuals received SSI benefits.

DI and SSI Benefit Applications and Continuing Eligibility Determinations—A beneficiary applies (or is reviewed for continuing eligibility) for DI or SSI benefit at an SSA District Office (DO). The beneficiary is responsible for providing the necessary evidence to determine eligibility, but the DO will assist in acquiring evidence.

The DO opens a file on the individual including all the known sources of medical evidence of disability. This is a face-to-face meeting with a DO representative who is not with the decisionmaker.

The DO determines eligibility based on all factors, except for medical/vocational factors.

¹⁸ Sylvia Hendel, Office of Prepaid Health Care, Health Care Financing Administration, conversation with author (Washington, D.C.: December 5, 1989).

¹⁹ Social Security Act, Title II, 42 U.S.C., Sec. 401, *et seq.*

²⁰ Social Security Act, Title XVI, 42 U.S.C., Sec. 1381, *et seq.*

The DO forwards the beneficiary's file to the Disability Determination Service (DDS), a state agency that contracts with SSA for determination of medical/vocational eligibility. DDS provides trained examiners and physicians to make eligibility determinations who perform the sequential evaluation of medical/vocational eligibility. The decision is based on an on-the-record review.

Prior to its determination, a DDS must—

- prepare each case for determination
- assemble available medical evidence
- arrange for an independent medical examination at its own option
- evaluate each case to see if it meets SSA disability criteria.

If a DDS denies eligibility or continuing eligibility, SSA must—

- inform the beneficiary in writing of the denial and medical basis for the denial
- notify the beneficiary of the right to request reconsideration of the denial

The beneficiary requests reconsideration at the DO which forwards the request to the appropriate DDS for determination. Prior to making a decision, a DDS must—

- re-examine all of the evidence in the beneficiary's file
- examine additional information submitted by or on behalf of the beneficiary
- obtain new medical evidence, if indicated
- designate an examiner and physician other than those making the initial determination

Except for reconsideration of decisions to terminate beneficiaries from DI benefits, reconsideration is an on-the-record review. In only one situation, if continued benefit is denied on reconsideration, the beneficiary may request a face-to-face hearing at the DDS.

If the benefit is denied, SSA must provide the beneficiary with notification similar to the initial determination notice.

The beneficiary may request a face-to-face *de novo* hearing before an SSA ALJ. The beneficiary may be represented.

If the ALJ denies the benefit, the SSA Appeals Council will review the case either at the beneficiary's request or on its own initiative, and decide or dismiss the case. This is an on-the-record review.

Any party may request a hearing in a U.S. District Court at which all parties may be represented by counsel. The hearing is based on evidence in the record only, unless there is substantial new evidence to be introduced.

In 1988, there were 1,516,873 initial applications for DI, SSI, and DI and SSI combined, of which 36 percent were allowed. Nearly half of those denied initial eligibility appealed for reconsideration. After all levels of appeal had been exhausted, an additional 21 percent of beneficiaries were declared eligible for benefits, bringing the total to 49 percent. For cases reviewed at the ALJ level in 1988, 59.2 percent were reversed or judged favorable to the beneficiary. Of the 318,134 continuing disability reviews, 88 percent of beneficiaries were continued. Nearly half of those terminated appealed. After exhaustion of the appeal process, an additional 21 percent of those terminated were continued on the roles.²¹

Department of Veterans Affairs

Veterans over 65 and totally disabled, who can meet a means test, may be eligible to receive pensions for nonservice-connected disabilities. Veterans with certain service-connected disabilities may be able to receive compensation. The amounts of the monthly payments for either of these programs are determined by disability ratings based on a statutory formula. Within the last two years, the review and appeal procedures for the disability compensation and pension programs have undergone major changes, some of which are still being put into place. Congress has established an independent Court of Veterans Appeals, granting veterans an appeal to a body outside of the Veterans Administration for the first time since establishment of the disability programs after the Civil War. Another recent change is the opportunity for an intermediate hearing and decision before a DVA hearing officer, after the initial determination by a three-person Rating Board, and prior to the appeal to the Board of Veterans Appeals.

The beneficiary files a claim for benefit with the Compensation and Pension Service (CPS) at a local office of the DVA.

A three-person Rating Board of two lay persons and a physician make the initial disability determination. Prior to their determination they must develop medical evidence, including ordering an examination

²¹ Ways and Means, *Background Material*, 49-52.

at a DVA medical facility, if they consider it appropriate.

The determination is based on application of an established point system, including a list of medical conditions considered sufficiently disabling to establish eligibility. The beneficiary is entitled to an informal hearing and to a service organization representative.

If the Rating Board denies the claim, the CPS sends the beneficiary a Notice of Decision including the rating decision and a statement that she/he can file notice of disagreement.

If the beneficiary files a notice of disagreement, CPS sends her/him a Statement of the Case—a detailed statement of facts, law and reasons for the decision, and a form on which to request an appeal to the Board of Veterans Appeals (BVA), a departmental appellate body. The beneficiary can request a hearing before the BVA, a CPS hearing officer (acting as an agent of the BVA to develop the record on which the BVA makes a decision), or a traveling BVA panel.

After receiving the Statement of the Case and prior to requesting an appeal the beneficiary has the option, on her/his own initiative, to request an informal reconsideration hearing before a CPS hearing officer. The hearing officer may uphold, reverse or remand the case to the Rating Board for further development. The beneficiary may be represented by a service organization.

The beneficiary can appeal the decision of the Rating Board or the hearing officer to the BVA. BVA hearings are based on the record developed by CPS hearing officers for the BVA. The BVA may uphold, reverse or remand the case for further development. The beneficiary may be represented by a service organization.

If the BVA denies the claim, the beneficiary may either request a reconsideration, appeal to the Court of Veterans Appeals or file the claim again with CPS for redetermination by the Rating Board. At this point, the beneficiary may be represented by an attorney.

The Court of Veterans Appeals is not yet operational, so that its procedures cannot be described.

The beneficiary may appeal from a denial by the Court of Veterans Appeals to the U.S. Court of Appeals for the District of Columbia.

In 1988, 2.2 million disabled veterans and 326,000 survivors received compensation; about 1.23 million

individuals received pensions. In FY 1989, 3,715,414 veterans' and survivors' benefits claims were adjudicated. Figures are not maintained on allowance and denial prior to the BVA level. In FY 1989, 38,673 cases were reviewed by the Board of Veterans Appeals; 14 percent were allowed, 62.6 percent were denied, and 22 percent were remanded to the field office for further development of the case.²²

Medicaid

Medicaid²³ is a federal-state matching entitlement program providing medical assistance for certain categories of vulnerable, low-income individuals. Within federal guidelines, each state designs and administers its own program. Review and appeal procedures must meet minimum federal standards.²⁴

States are required to offer all beneficiaries an opportunity for a fair hearing whenever they are denied or terminated from eligibility; when their claims are denied or not acted upon promptly; or when the Medicaid agency takes action to suspend, terminate, or reduce services. States also must describe their review and appeal procedures in the state plan that is submitted to the federal government for funding.

Medicaid review and appeal procedures must include:

- a system for hearings
- notice
- right to a hearing in certain circumstances
- guarantee of maintenance of service until determination
- right to review of initial decision by state agency including *de novo* hearing at request of the beneficiary
- hearing procedures that meet federally mandated standards

Basically, the state hearing system is required to meet the standards set out in *Goldberg v. Kelly*.²⁵ The Medicaid agency must provide for a hearing before the agency or a local level evidentiary hearing with a right of appellate hearing before the agency. The agency must publicize its hearing procedures and inform Medicaid beneficiaries in writing of their review and appeal rights. The agency must allow

²² Michael Dunlop, Department of Veterans Affairs, conversation with author (Washington, D.C.: January 11, 1990).

²³ Social Security Act, Title XIX, 42 U.S.C., Sec. 1396, *et seq.*

²⁴ 42 CFR Ch. IV, Subpart E.

²⁵ *Goldberg v. Kelly*, 397 U.S. 259 (1969).

beneficiaries to be represented by a friend or an attorney.

Notice—Advance notice to beneficiaries is required to state what action the agency intends to take and the reasons for the intended action. It also must include a statement of the law and an explanation of the beneficiary's right to an evidentiary hearing, the circumstances under which a hearing will be granted, and the circumstances under which Medicaid will be continued during the pendency of the review process.

Right to a Hearing—The agency must grant an opportunity for a hearing to beneficiaries requesting it whose claims have been denied or not acted on in a timely manner, and to those who request it because they believe the agency has taken erroneous action. The agency must allow beneficiaries a reasonable time from the date of mailing notices of adverse actions to request hearings. The agency may conduct group hearings provided that it follows federal and state procedures for hearings and permits each beneficiary to be individually represented.

Guarantee of Maintenance of Service Until Determination—The agency may not terminate or reduce services until a decision is rendered after a hearing unless the sole issue is determined to be one of law or policy. If the agency action is upheld at the hearing, the state may institute procedures to recoup the cost of any services furnished the beneficiary between the time of agency notice of adverse action and the time of post-hearing decision.

Right of Review—If the local level evidentiary hearing results in the denial of a claim, the state agency must inform the beneficiary of the decision and of the right to appeal to the agency, in writing, within 15 days of mailing the notice. Unless the beneficiary requests a *de novo* hearing, the agency may review the record of the initial evidentiary hearing. Hearings must be conducted at a reasonable time, date and place, after adequate written notice of the hearing, by impartial individuals who have not been involved in the initial determination. If a medical assessment is deemed necessary, this must be obtained at the agency's expense.

Meeting Federal Standards—The agency must allow the beneficiary to:

- examine the content of the beneficiary's case file
- examine all documents and records to be used by the agency at the hearing
- bring witnesses
- establish pertinent facts and circumstances
- present argument

- confront or cross-examine adverse witnesses.

The hearing decision must be based exclusively on the evidence introduced at the hearing. The record must consist only of the transcript and exhibits, all papers and requests filed in the proceeding, and the recommendation or decision of the hearing officer. The beneficiary must have access to the record. The decision must be written, summarize the facts, identify the relevant law, and specify the reasons for the decision. It must be forthcoming within 90 days of the request for a hearing.

A Look at the Medicaid Procedures—Federal Medicaid review and appeal standards are relatively stringent. Many of the federal benefit programs do not impose upon themselves the degree of accountability required of state Medicaid agencies. In addition, the level of participation of beneficiaries and their representatives in the mandated Medicaid review and appeal process is higher than in most federal programs, and the requirements to inform beneficiaries about all aspects of the process are more substantial.

Benefit Program Review and Appeal Procedures—Observations

This section has described the various ways in which benefit programs structure review and appeal procedures, and the requirements placed on beneficiaries desiring to contest adverse claims decisions. The complexity of these procedures and the detailed understanding necessary for beneficiaries to use them effectively appear overwhelming. Due process requires benefit programs to provide certain safeguards which might complicate the review and appeal process to some extent. But many of the more subtle aspects of the procedures described are intended to serve program purposes unrelated to due process.

The statistics on the number of reviews and appeals requested which accompany each benefit program description emphasize this problem. In each program, the number of initial eligibility applications or claims denied is significantly larger than the number of reviews or appeals requested. Despite the fact that in most programs the percentage of reversals of denied claims is significant at both the review and appellate levels, the vast majority of beneficiaries receiving adverse determinations do not take advantage of these procedures. No systematic analysis has been done of the reasons for this. It is possible that large numbers of beneficiaries accept claims, trusting in the fairness of the determination process. Other plausible reasons

for not pursuing review and appeal remedies are ignorance of rights or inability to cope with the complexity of the process. Failure to assert rights for these reasons amounts to a denial of due process.

WHAT ARE THE REVIEW AND APPEALS PROCEDURES OF PRIVATE LONG-TERM CARE INSURANCE POLICIES

The insurance industry generally has no legal obligation to provide a claims review and appeal procedure. If individual insurance companies elect not to, they have no duty to implement procedures that conform to due process standards. Some insurance companies may view such procedures as good public relations or as providing them with a marketing advantage in a highly competitive market. Although the review and appeal procedure itself is generally not subject to regulation, redress may be available in some circumstances. For example, failure to pay valid claims may be cause for intervention by state insurance departments. Also, employment-based policies are required to comply with certain provisions of ERISA, including that there be a review process and that claims determinations be made in a timely manner.

Earl Pomeroy, the President of the National Association of Insurance Commissioners, and Insurance Commissioner for North Dakota, indicates that state regulation has not been concerned with requiring insurance companies to provide for review and appeal of denied claims. According to Mr. Pomeroy, insurance commissioners are reluctant to support any regulations that would remove the claims settlement function from insurance companies and put it under governmental or independent control.²⁶

Two insurance carriers with experience in employment based group long-term care policies, Aetna and Travelers, have developed internal review and appeal procedures and written criteria for eligibility assessment. Both of these carriers stress the importance of an assessment instrument that can be used by assessors throughout the country to insure consistent benefit eligibility assessment for all insureds. Both carriers use criteria based on the number of activities of daily living (ADLs) with which the insured requires assistance. The criteria are stated in the insurance contract; but internal directives offer assessors more specific guidance about how to apply the criteria.

ORS LTC Aetna

For community-based long-term care, the Aetna plan emphasizes the importance of the on-site visit of a case manager/assessor who determines an insured's functional dependency by first-hand observation. The physician's statement and medical record form part of the file on which a determination is made, but the measurement of ADLs is considered the most important information.²⁷ The Aetna plan provides for daily payment of a flat amount to insureds meeting the functional dependency criteria.

The procedure for review of denied claims is not included in the plan information. It has, however, been described by an Aetna representative. When an individual insured under the ORS LTC Plan requests coverage on account of functional dependency, Aetna sends an employee or contract case manager to do an on-site assessment based on a standard set of criteria. The case manager—a nurse or social worker—must determine whether the individual is functionally dependent in at least two ADLs or has certain other qualifying disabilities. The case manager does not participate in the determination of eligibility for benefit. She/he makes a report to Aetna which considers this, along with a physician's statement and other medical or social service reports, in determining the whether or not the insured is eligible for benefits.

If the initial claim is denied, an internal claims committee including a physician, an attorney and a claims supervisor unrelated to the initial decisionmaker examines the file. The committee may order a medical or other examination or additional information.

If the committee denies the claim, the case is reviewed by another case manager working with the same claims committee. The insured is not represented and there is no face-to-face interview with the decisionmaker.

If the committee intends to deny the claim again, an Aetna representative talks with the insured's family and tries to help them understand the reasons for the claim denial. These meetings may be face-to-face or on the telephone. If functional dependence has not progressed far enough to warrant coverage, the family or insured are encouraged to reapply in a few weeks or months.²⁸

²⁷ Travelers Insurance Co., ORS LTC Plan, Complete Description, December 1988, 7 contains detailed listing of criteria.

²⁸ Joseph Hancock, Aetna Insurance Co., telephone conversation with author, November 10, 1989.

²⁶ Earl Pomeroy, telephone conversation with author, December 11, 1989.

Travelers Long-Term Care Insurance Plan

The Travelers plan offers insureds meeting the criteria of functional dependency the option of receiving a flat daily minimum benefit amount or a payment for actual services received (or up to five times the amount of the minimum benefit, whichever is less). The latter option requires the insured to accept a care plan that is coordinated by a case manager on contract to Travelers. The same review and appeal process is available to insureds who have either been assessed as ineligible for long-term care benefits or who object to aspects of the care plan. Eligibility to receive benefits or care management is contingent on the insured having a qualifying disability due to an accidental injury or sickness. The insured must be determined by a Travelers representative to need assistance with two or more ADLs from a list set out in the Certificate of Insurance.²⁹

When an insured first requests long-term care benefits or disputes aspects of a care plan, the Patient Care Coordinator, a Travelers employee, gathers the relevant information, speaks with the insured's physician, family, and the case manager in order to develop background information. The case manager then makes an on-site evaluation based on standardized criteria for measuring ability to complete ADLs. If the case manager and the Patient Care Coordinator agree to deny the claim, Travelers sends the insured a denial letter. This letter must include an explanation of the reasons for denial and information about how to request a review. The insured is encouraged in this letter to include additional information considered of value to the reviewer and to ask for copies of documents used in the determination process.

An insured requests a review by contacting the Patient Care Coordinator. The review is made by a contract physician who has had no previous involvement in the case. If the review results in a denial, the insured may appeal to have a board certified geriatrician, on contract to Travelers and not previously involved in the case, do a second review. A denial at this stage is final.

Decisions are made within 60 days of receipt of request for review or of date insured supplies all relevant information. Notice of denial is in writing accompanied by reasons for the decision written in language that the insured can understand.³⁰ There are no face-to-face meetings with the decisionmaker except for the initial case manager's assessment.

WHAT SHOULD POLICYMAKERS CONSIDER IN DEVELOPING THE REVIEW AND APPEAL PROCESS FOR A LONG-TERM CARE PROGRAM?

A benefit program's review and appeal procedures should be developed in the context of the total program. Procedures in existing programs vary considerably, primarily reflecting the diverse objectives of the programs themselves.

Underlying Program Considerations

Considerations underlying the operations of these programs significantly influencing the structure of the review and appeal process include:

- Type of benefit
- Source of financing
- Structure of program administration
- Cost containment measures

Type of Benefit—The criteria for establishing initial and continuing eligibility vary substantially depending on type of benefit. Some benefit programs provide a beneficiary with periodic compensation if she/he is determined to have a chronic disability that results in eligibility (DI, SSI, DVA). Others reimburse an eligible individual for certain specific medical or skilled care expenses, or determine eligibility for a benefit on a case-by-case basis in advance of providing a specific service (Medicare, Medicaid). Programs providing regular compensation based on beneficiaries' disabilities, or payment for treatment of chronic medical conditions, are able to build into the claims process time for reasoned initial claims determinations (DVA, SSD, SSI, Medicaid). In programs providing reimbursement for acute medical care (Medicare) this is more difficult.

Source of Financing—Depending on a benefit program's source of financing, its review and appeal process may be required to meet differing legal requirements. Generally, entitlement programs are funded from federal or state tax revenues (Medicaid, SSI). These have more stringent due process requirements than other programs because they serve the most vulnerable segments of the population. Although DVA programs are federally funded, the historical justification for a somewhat limited appeal process was that these benefits were discretionary. The social insurance programs (DI, Medicare) theoretically have somewhat more latitude in meeting due process requirements for review and appeal procedures than do entitlement programs. In practice, however, the

²⁹ Group Long Term Care Insurance Plan (October 1989), 4, 5.

³⁰ Aetna Group Long Term Care Insurance Plan Claims Information (October 1989), 3.

review and appeal procedures of DI are governed by the same statutory and regulatory language as SSI.

Structure of Program Administration—When a benefit program directly administers its own review and appeal process, its obligation to provide beneficiaries with due process is clear. When a program delegates authority for part or all of the review and appeal process to a private organization, the legal relationship of that organization to the agency becomes critical to determining its due process-related obligations to beneficiaries.

Medicare—Medicare, for example, has delegated an extraordinary amount of authority over the review and appeal processes in all of its programs to various private organizations—insurance companies, HMOs and PROs. Commentators have identified two key issues resulting from this delegation that those designing a new benefit program need to consider: 1) the appropriateness of delegating major program functions to private organizations; and 2) the adequacy of the procedures under this arrangement to protect Medicare beneficiaries' interests.³¹

The U.S. Supreme Court in *Schweiker v. McClure*,³² decided that hearings under Medicare Part B, delegated by HCFA to private insurance carriers, are constitutional if they provide adequate procedural due process. Despite this decision, the issue of the appropriateness of delegating benefit determinations to private contractors remains controversial. In 1986, Congress enacted provisions requiring that, at a beneficiary's request, HCFA must provide for a hearing by an SSA ALJ on appeal from a Part B carrier hearing if the amount in issue exceeds \$500.³³ Even though the ALJ is an employee of SSA, the office of ALJ is mandated to provide independent adjudication.

Social Security Programs—The Disability Advisory Committee to the Commissioner of Social Security was appointed in February 1989 to examine and make recommendations improving the effectiveness of the SSA (disability claims review) and appeal process. As contractors to SSA, state DDSs make initial claims and reconsideration determinations regarding eligibility for medical disability pensions. The committee reported a lack of uniformity among state DDS personnel in application of standards to specific eligibility determinations. It found that a wide variation among states in allowance rates had resulted in a high rate of appeals and reversals of determinations at the ALJ

level.³⁴ It recommended that SSA pursue specific management initiatives to improve uniformity in, and accountability for, disability determinations among DDSs.³⁵

Cost Containment Measures—Ideally, cost containment decisions should be made in relationship to a benefit program's basic policies and practices, not in the design or operation of its review and appeal procedures. Benefit programs have been criticized, however, for using the review and appeal process to balance cost containment considerations against program requirements that funds be disbursed to eligible beneficiaries.

Containing Costs Within Benefit Programs—Two significant approaches to containing costs are: 1) to reduce administrative expenditures, including expenditures on review and appeal procedures and 2) to increase determinations of noneligibility for benefits.³⁶ Selection of either of these options may involve both a monetary cost to the program and a cost in program credibility.

The first approach may limit an agency in offering an effective review and appeal process. SSA, for example, has been criticized by the National Association of Disability Examiners (NADE) when, as part of a drive to increase administrative efficiency, it placed a limit of 37 percent on the number of cases in which disability examiners can hire consulting physicians to examine beneficiaries. NADE asserts that this seriously disadvantages beneficiaries because it suppresses the examiner's ability to create an adequate record.³⁷ The second approach may result in incorrect and unfair disability determinations. These could lead, in turn, to increased resort by beneficiaries to the review and appeal process. A recent congressionally-mandated report of the Advisory Committee on Medicare Home Health Care that examined the reasons for an overwhelming number of home care benefit denials found that the increase in denials was related in part to deliberate HCFA practices.³⁸

Containing Costs Through Placement of Risk—Congress has developed specific policies intended to contain costs by placing the risk for inappropriate use of the health care system on providers and beneficiaries rather than on benefit programs. One such policy re-

³⁴ Disability Advisory Committee to the Commissioner of Social Security, *Report* (July 25, 1989), 1.

³⁵ Disability Advisory Committee, *Report*, Tab B, 2, 17-18.

³⁶ Eileen Sweeney, National Senior Citizens Law Center, conversation with author (Washington D.C.: November 1, 1989); see *Duggan v. Bowen*, 691 F.Supp. 1487, 1500 (DDC 1988).

³⁷ K.J. Gunter, NADE President, letter to David Rust, Social Security Administration, U.S. Department of Health and Human Services, April 1989.

³⁸ Advisory Committee on Medicare Home Health Care, *Report to Congress and the Health Care Financing Administration*, July 1, 1989.

³¹ Eleanor Kinney, *Medicare Appeals System*, 97.

³² 456 U.S. 188 (1981).

³³ 42 U.S.C., Sec. 1395ff.

quires prospective payment and bases it on pre-established Diagnosis Related Groups (DRGs) within which a beneficiary's condition falls. It bases reimbursement on the average length and cost of treatment for a condition rather than on the actual cost of services provided.

Another policy establishes liability in beneficiaries and providers for the cost of services already provided that are not covered by Medicare's "medically necessary" standard. A policy waiving liability of beneficiaries or providers deemed unaware that Medicare would not cover the service was adopted subsequently to mitigate the impact of the first policy. In such situations, either Medicare or the provider must bear the cost of the care provided. If Medicare determines that the provider should have been aware that the service or confinement was not covered by Medicare, the provider is liable.

Finally, Congress has authorized HCFA to contract with risk HMOs to provide medical care to those Medicare beneficiaries choosing this option. These private organizations provide care to members based on a pre-determined per capita fee. Reimbursement from Medicare is based on these fees, so that the burden of estimating accurately the cost of medical care for a contract period falls on the HMO. The HMO is able to pass on the burden of underestimating costs to beneficiaries by limiting or denying health care in certain situations in order to reduce costs.

The economic and public policy considerations of risk placement are complex. Placing a heavy risk for incorrect decisions as to covered services on providers has led them, quite naturally, to attempt in various ways to transfer this burden to beneficiaries.

Transferring Costs to Beneficiaries—SNFs and HHA's—With respect to SNFs and HHAs, Medicare Part A encourages providers to transfer the risk for noncovered services to beneficiaries by requiring beneficiary claims to be made by providers on behalf of beneficiaries, rather than by beneficiaries directly. But Medicare also penalizes providers for submitting too many beneficiary requests for payment for services Medicare does not cover.

Frequently, if service providers are unsure about whether Medicare will cover the costs of a particular service, they simply inform beneficiaries that the service is not covered, rather than waiting for a Medicare determination as to coverage. In this way, providers can request payment directly from the patient and not run the risk of providing an expensive service for which, at some later date, Medicare may refuse reim-

bursement.³⁹ This practice leaves beneficiaries unable to exercise their review and appeal rights because technically there has never been a decision of noncoverage made by Medicare.

Theoretically, beneficiaries can demand that providers submit claims to Medicare on their behalf. Beneficiaries' advocates indicate that most do not do so. This may be either because they are uninformed of their rights or are unwilling to antagonize the providers whose interests they perceive as conflicting with their own, but on whom they depend for essential care.⁴⁰ In addition to inhibiting beneficiaries in the exercise of their review and appeal rights, a system that makes providers responsible for claims decisions undermines the trust relationship critical to their ability to serve their patients effectively. In the case of Medicare, the result has been to increase both beneficiary and provider dissatisfaction with Medicare's ability to make fair decisions.

Recently, HCFA entered into a settlement agreement with representatives of beneficiaries whereby it agreed to require that providers give beneficiaries written notice, uniform among all providers, of the right to request a Medicare determination if the provider decides that particular services are not covered by Medicare, and to withhold request for payment until after the fiscal intermediary's initial Medicare decision.⁴¹ While this agreement partially alleviates concerns of beneficiaries, it increases the burden on providers, and inadequately addresses the basic source of conflict between the two. A policy that would allow beneficiaries to submit claims themselves and to withhold payment until they are either reimbursed or have exhausted appeal rights might satisfy beneficiaries' concerns. But the cost to providers of extensively deferred payment for services would be substantial.

Transferring Costs to Beneficiaries—Hospitals—For beneficiaries in hospitals, the verbal request from the hospital or physician that the patient leave could also result in denial of covered care. Patients are given a general notice of rights at the time of admission that states, among other things, that they may formally object to such a request. Representatives of beneficiaries are concerned, however, that most patients would not be able to advocate effectively about their discharges because of their illness or the stress of hospitalization. Many may not even remember receiving

³⁹ Susan Pettey, American Association of Homes for the Aging, conversation with author, Washington, D.C., November 30, 1989; Selected Staff of Bureau of Program Operations, Health Care Financing Administration, conversation with author (Baltimore, Md.: November 17, 1989).

⁴⁰ William Dombi, National Home Care Association, conversation with author (Washington, D.C.: October 11, 1989).

⁴¹ *Sarrasat v. Sullivan*, C88-201-61 RPA USDC, NDCal. (May 4, 1989).

a statement of rights.⁴² Upon being told it is time to leave the hospital and that Medicare will not cover a continued stay, most beneficiaries leave voluntarily.

But the request itself is not a Medicare determination of noncoverage. Particularly where the hospital and physician agree about the discharge, beneficiaries rely on their expert judgment, both that continued hospitalization is not necessary, and that Medicare will no longer pay for it. Because of the DRG system, hospitals, in particular, have incentives similar to SNFs prematurely to discharge beneficiaries whose continued stay might not be covered by Medicare. Otherwise, they may be held liable if the services ultimately are not covered and they have failed to so notify the beneficiary. There is, however, limited protection of beneficiaries against arbitrary discharge: if a beneficiary is rehospitalized in any hospital for a similar condition within 30 days of discharge, the hospital of original discharge is penalized.

Program Considerations in Long-Term Care

Although the focus of a long-term care program would be somewhat different from that of the existing benefit programs, each of the program considerations described above is critical to the design of its review and appeal procedures. In addition, particular characteristics of the benefits and structure of a long-term care program will have an impact on its review and appeal procedures.

Determination of Benefits—Significant considerations in determining eligibility for participation in a long-term care program and for receiving reimbursement for specific services are:

- Once an individual is determined to be eligible for long-term care, decisions are more likely to be about changes in the amount or level of services to which she/he is entitled than about the total discontinuation of all services to that individual
- A beneficiary's needs generally will be for custodial or social support rather than skilled nursing or medical services
- When available, a beneficiary's family or members of her/his informal support system are likely to participate with the beneficiary and long-term care program staff in planning for a beneficiary's care

- Long-term care involves decisionmaking about benefits to meet both chronic and acute care needs, rather than focusing on one or the other.
- The central role of the case manager—one who designs, coordinates and monitors the long-term care plan for the beneficiary—is without parallel in existing benefit programs in terms of power over the beneficiary, and potential for ambivalent allegiance between the client/beneficiary and the long-term care program employer.

Program Structure—Inevitably, some decisions made about the structure of the long-term care program will have adverse economic, social or therapeutic consequences for beneficiaries. Such decisions will be a basis for beneficiary complaints. These include:

- whether an applicant meets the various eligibility criteria such as sufficient dependency in ADLs to participate in the program
- whether the setting in which a beneficiary could benefit most is community or institutional care
- whether, and at what point, a beneficiary is eligible for specific benefits or services, and the duration and frequency of these services
- establishing the appropriate relationship of the individual or organization responsible for assessing eligibility to those responsible for developing care plans or making specific care-related decisions about beneficiaries
- establishing the relationship of the assessment and care management functions to the agency financing the long-term care program
- determining the mechanism for frequent reassessment of a beneficiary's needs or of the benefits or services to be provided in a long-term care program
- providing quality control activities such as monitoring the level of services provided under the long-term care program

Claims Decisionmaking in Long-Term Care—In order to assure the credibility of the program with beneficiaries and the general public, the claims decisionmaking function should, to the extent possible, be independent of eligibility assessment, care plan design, monitoring or service provision. Confusion of roles could arise in the administration of a long-term care program that does not separate these functions adequately.

The Case Manager—Care Plan Design and Monitoring—The role of the case manager raises issues regarding review and appeal procedures that arise infrequently in existing benefit programs. (There are probably parallel situations in home health care under

⁴² Charles C. Hulin, Center for Medicare Advocacy, telephone conversation with author, November 8, 1989.

Medicare and Medicaid, and in Medicare HMOs.) The significant care-related decisions in a long-term care program are likely to be made by a case manager—for example, a nurse or social worker—who establishes a care plan and manages the care to be provided the beneficiary. If the beneficiary is able to remain in the community, the case manager will identify and arrange for the provision of appropriate services to the beneficiary, and determine the number of, hours, days or weeks the service should be provided.

A critical issue for the case manager may be that of serving two masters. The case manager must have a relationship of trust with the beneficiary in order to gain the cooperation necessary to implement appropriate care decisions. She/he might also be expected by the agency financing or administering the program to enforce certain program guidelines that result in containing costs by limiting services or benefits.

Cost Containment—Reasonable cost containment measures would include efficient division of the case manager's time among beneficiaries, or developing care plans that are closely tailored to a beneficiary's minimum needs. If a case manager is unduly vulnerable to pressure from the benefit program, it may become difficult to resist directives to increase the case load or trim the care plan. If the program is financed similarly to Medicare HMOs, so that the case manager receives a flat per-client monthly fee based on a predetermined estimate of cost of service to all clients served, there is likely to be substantial incentive to keep costs down. If this occurs at the expense of fair decisions about services to beneficiaries, a due process problem can arise. One experienced benefit program administrator warned that a case manager under the close control of the funding agency, making decisions about benefits, generally is perceived with skepticism by the beneficiaries.⁴³

Mitigating Considerations—According to the National Association of State Units on Aging (NASUA), the experience of state financed long-term care programs is that case managers in community care programs have not been placed in conflicting roles. Currently, in most states, the cost of community care is tied to the daily nursing home rate which is substantially higher than the cost of services in the community. Consequently, home care programs rarely spend their annual budgets and are under no pressure to reduce program costs beyond appropriate levels. In addition, community long-term care case managers may tend to authorize more services than most older persons want. Many elderly are wary of managed

care programs and see those who provide these services as intruders into their lives.

Also, the community-based nature of the program may work as a counter-weight to any bureaucratic pressures on case managers to favor administrative considerations over client needs. In contrast to the Medicare program, whose initial decisionmakers are distant, inaccessible insurance companies, community long-term care case managers are attuned to community values and are required to maintain an ongoing relationship with clients about whom they make adverse decisions.⁴⁴

WHAT HAS BEEN THE EXPERIENCE OF EXISTING BENEFIT PROGRAMS WITH DEVELOPING AND IMPLEMENTING REVIEW AND APPEAL PROCEDURES THAT PROVIDE ADEQUATE DUE PROCESS?

The primary purpose of due process is not to insure that as many beneficiaries as possible be determined eligible for benefits. Rather it is to increase the capacity for fair and accurate decisionmaking about beneficiaries' rights—"to pay worthy claims and reject unworthy ones."⁴⁵

The Complexity of the Process

The review and appeal procedures of each of the benefit programs described in this report are required to meet constitutional requirements for review and appeal procedures. But the concepts of what constitutes due process are complex and subject to differing interpretations.

During the last decade the review and appeal procedures of Medicare, DI, SSI and DVA have all been the targets of extensive Congressional oversight. This has led to legislation revamping some of these procedures in order to provide increased due process to beneficiaries. In addition, in recent years, the federal courts have ordered the agencies administering these programs to make major changes in review and appeal procedures to further protect beneficiaries. Finally, several administrative commission reports and U.S. General Accounting Office audits have recommended ways to ensure an improved level of due

⁴³ Patricia Booth, Division of Peer Review, Office of Peer Review, Health Quality Standard Bureau, Health Care Financing Administration, conversation with author (Baltimore Md.: November 17, 1989).

⁴⁴ Diane Justice, National Association of State Units on Aging, conversation with author (Washington, D.C.: November 15, 1989).

⁴⁵ Jerry Mashaw, "Bureaucratic Justice," *Symposium on Federal Disability Benefit Programs*, American Bar Association, 1985, 191.

process for beneficiaries. Significant goals of due process addressed in this section include the right to:

- Representation by lay advocate or attorney
- Adequate notice and timely determinations
- Access to the information on which determinations are based
- A decision based on an adequately developed record
- Make a verbal statement in front of the decisionmaker
- A hearing prior to denial or termination of a benefit, if possible
- A determination by an impartial decisionmaker

This section examines the practical difficulties that benefit programs have in achieving these goals, using illustrations from past and current experience of these programs.

Right to Representation

Because there is an inherent lack of parity between the two parties, vulnerable elderly or disabled beneficiaries frequently need representation when confronting powerful government benefit programs. In addition, beneficiaries may need assistance of trained individuals in order to prepare adequately for reviews and appeals.

Despite the availability of several sources of attorney compensation, a significant number of beneficiaries do not have, and cannot get, legal representation at appellate level hearings. In addition, few beneficiaries have either legal or lay representation during the early stages of the review process, either because they are not adequately informed about its usefulness and availability, or because it is unavailable.

Nonadversarial Process—The review and appeal process in benefit programs is generally considered nonadversarial. Theoretically, SSA ALJs and the BVA wear three hats—objective judge, government representative, and spokesperson for the beneficiary, particularly if she/he is unrepresented. The government is not represented by counsel at any stage of the administrative process. Several years ago SSA decided to experiment with using a system providing government with representation by counsel at beneficiaries' hearings before an ALJ. Both SSA and advocates for beneficiaries indicate, for different reasons, that this was not effective. One reason on which both sides agree is that, as the procedure became increasingly adversarial, hearings became more technical and

time consuming.⁴⁶ Eventually, a federal court ruled that the experiment as conceived and operated by SSA was unconstitutional.⁴⁷

In general, both advocates and agency administrators consider that the nonadversarial process is more effective than traditional trial-type procedures would be. Attorneys representing veterans express some concern that BVA may have difficulty maintaining independence from DVA because most individuals appointed to serve on BVA are long-time employees of DVA or are involved in other ways with veterans' groups.⁴⁸

Representation in Benefit Programs—Representation increases the percentage of allowances in benefit programs. All benefit programs permit beneficiaries to be represented by attorneys or lay representatives at some stage in the claims process. Although early representation may increase the likelihood that beneficiaries will be satisfied with benefit program decisions, most programs do not encourage this.⁴⁹

SSA—Historically, DI and SSI have permitted legal or lay representation from the earliest stage of the claims process. As a practical matter, however, beneficiaries generally are not represented until the hearing before an ALJ. According to SSA, 85 percent of beneficiaries appearing before an ALJ are represented, 67 percent of these by attorneys.⁵⁰

Medicare—In Medicare proceedings, beneficiaries generally are not represented until the ALJ hearing, if at all. Medicare rules permit representation at a Part B carrier level hearing and at an HMO reconsideration hearing, if the beneficiary requests such a hearing. Under Part A, there are no hearings by Medicare officials or agents, but beneficiaries have a right to an ALJ hearing at which they can be represented. The PRO's obligation to contact beneficiaries personally to discuss disputes over hospital discharge is not a hearing as contemplated by due process.

DVA—The DVA has a long history of preferring lay over legal representation at all levels of the process. Until recently, there was a statutory limit on attorneys' fees, dating from after the Civil War, of ten dollars per case. Charging fees in excess of this

⁴⁶ Eileen Sweeney, conversation with author; Jean Hinckley, Social Security Administration, conversation with author, November 6, 1989.

⁴⁷ *Salling v. Bowen*, 641 F.Supp. 1046, USDC WDVA, (1986).

⁴⁸ Michael Wildhaber, National Veterans Legal Services Project, conversation with author (Washington, D.C.: December 4, 1989).

⁴⁹ Ayn Crawley, Legal Counsel for the Elderly, conversation with author (Washington, D.C.: November 2, 1989); Jean Hinkley, conversation with author.

⁵⁰ U.S. Department of Health and Human Services, Social Security Administration, "Attorney Fees Under Title II of the Social Security Act." *Report to Congress*, July 1988, 12.

amount was a felony. For many years, congressionally chartered veterans' service organizations have represented beneficiaries in these proceedings for free from filing the initial claim through the appeal to BVA. The law requires service organizations to represent any veteran requesting it regardless of service organization membership or apparent validity of the claim. The proposed rules of the newly established Court of Veterans Appeals authorize legal counsel and certified lay representatives to represent beneficiaries before the Court. Attorneys may represent beneficiaries in BVA proceedings, but only after a case has gone before the BVA and been denied, and is being reopened at the initial decision level for a new review and appeal cycle.

Critics of the service organization representation system contend that these organizations are too closely tied to DVA to be able to provide fair representation in claims against DVA.⁵¹ Service organization representatives consider that their frequent and close contact with DVA enables them to negotiate quite effectively on behalf of clients.⁵²

Fees—Frequently, beneficiaries are not represented by attorneys at benefit hearings because they cannot afford the fees. Under the Social Security Act, if a beneficiary prevails in a DI case, the ALJ may order that a payment of up to 25 percent of the amount of a past due claim be withheld from SSA's payment to the beneficiary and paid directly to the attorney. In SSI and Medicare cases, the ALJ may order the same amount of payment, but SSA and HCFA do not deduct the amount from beneficiary's check.⁵³ The amount of payment for services rendered earlier than the ALJ stage in these programs is between beneficiary and counsel.

Under the Veterans Judicial Review Act, attorneys seeking compensation directly from beneficiaries must file a copy of the fee agreement with the Court of Veterans Appeals which may affirm the agreement or order it reduced. Decisions to affirm are based on reasonableness of the fee. If an attorney has a contingent fee arrangement with the beneficiary, it may not exceed 20 percent of past-due benefits.⁵⁴

BVA may determine a reasonable fee for administrative representation which also may not exceed 20 percent of past-due benefits for contingent representation. DVA is setting up a system to pay attorneys whose clients prevail prior to sending the past-due benefits to beneficiaries.

Attorneys representing benefit program beneficiaries before federal courts may receive compensation under the Equal Access to Justice Act.⁵⁵ They will also be able to receive compensation from this source for representation before the Court of Veterans Appeals.

Legal services attorneys sometimes represent low-income beneficiaries at ALJ hearings. In addition, some states (e.g. CT, CA) have created services that represent beneficiaries in Medicare, DI and SSI cases. If a significant number of individuals can be transferred from state to federal benefit program rolls, effective advocacy can reduce state expenditures on health care benefits.

Adequate Notice

Due process requires that beneficiaries receive two types of notice: claims denials and procedures for review and appeal. Frequently, benefit programs combine both types of notice in one missive.

Elements of Notice—

Denial of Benefits—When an individual's medical condition or eligibility for skilled care are at issue, the denial or termination notice must indicate why her/his condition does not warrant a particular disability status, course of treatment or level of care.⁵⁶ Implementation of this requirement has resulted in litigation. A federal district court has decided, for example, that if a particular administrative procedure, such as a utilization screen, is used to determine that an individual is no longer entitled to a particular course of treatment, the notice must identify the screen. In this way, a beneficiary can rebut the validity of its application in her/his case.⁵⁷

Beneficiaries' Rights—In addition, notice must contain information about beneficiary's appeal rights: the time, date and place of filing a request for appeal and any hearings that the beneficiary is entitled to attend. Benefit programs have been criticized for distributing unclear statements of beneficiaries' rights or notices containing differing outcomes or inconsistent information regarding the determination of similar claims.⁵⁸

Another ground for dissatisfaction is that benefit programs place the initiative for requesting reviews on beneficiaries by not automatically informing them

⁵¹ Michael Wildhaber, conversation with author.

⁵² John A. Sommer, Jr. and Philip R. Wilkerson, American Legion, conversation with author (Washington, D.C.: January 16, 1990).

⁵³ 42 U.S.C., Sec. 206(a); 42 U.S.C., Sec. 1631(d)(2).

⁵⁴ 38 U.S.C., Sec. 4063.

⁵⁵ 28 U.S.C., Sec. 2417 (b), (d).

⁵⁶ *Gray Panthers v. Schweiker*, 652 F.2d 146, 1981.

⁵⁷ *Vorster v. Bowen*, 709 F.Supp. 934, (CD Cal. 1989) 1989.

⁵⁸ Michael Parks, Bet Tzedek Legal Services, telephone conversation with author, October 23, 1989; Susan Pettey, conversation with author.

that certain types of review procedure are available. For example, veterans' service organizations have criticized DVA for not publicizing the availability to beneficiaries of certain intermediate level hearings or of BVA reconsideration hearings.⁵⁹

Inconsistent Notice—Frequently, inconsistency results when a benefit program delegates its review and appeal functions to contract organizations without retaining substantial control over their performance. Currently, for example, presentation to Medicare Part A beneficiaries of notice of appeal rights at time of discharge depends on the policies of individual hospitals. The Administrative Conference of the United States⁶⁰ has recommended that HCFA amend PRO regulations to ensure that all Medicare beneficiaries are informed of their appeal rights at the time they are notified of the hospital's intention to discharge them.

The review practices of Medicare HMOs, including content of notices, are almost totally unsupervised by HCFA. Although HCFA instructs HMOs to provide beneficiaries with written reasons for denial, HCFA is aware that many do not comply.⁶¹ In response to pressure from the courts, HCFA is taking more direct responsibility for the conduct of its SNF and HHA contractors regarding notice procedures.⁶²

Clarity of Notice—Although beneficiaries' representatives generally laud Medicare for providing all hospitalized beneficiaries with a general notice of their appeal rights on admission, some also consider this statement to be unnecessarily vague.⁶³ Others concede that a general notice, meaningful to all beneficiaries, is especially difficult to formulate.⁶⁴ The Disability Advisory Committee recently has recommended that SSA improve its review and appeal process by providing beneficiaries with "written clarification of the law and regulations so as to specify the rights and responsibilities of the parties to the process. . . ." ⁶⁵

Problems With Notice of Denial—Many benefit program notices lack clarity and specificity. Simplicity of language is particularly important when the beneficiary population is relatively uneducated. But notices

are required to provide beneficiaries with a lot of information, so that both language and presentation quickly become complicated. In addition, computerization of notices has rigidified notice design. Frequently, rather than using lay vocabulary, the language of a notice tracks the wording of a statute or regulation. A professor of linguistics who has consulted to the Social Security Administration on rewriting its notices has observed that "bureaucrats learn to use the jargon and acronyms of their own agencies but they tend to exert little effort to communicate effectively with the world outside the agency." ⁶⁶

Criticisms of Notices—The description of the reasons for benefit denial or termination seem especially difficult to articulate. Recent legislation responding to a GAO criticism of DVA notices requires DVA to include more specific reasons in its claims denial notices.⁶⁷ GAO found that in 60 percent of compensation cases notices inadequately explained reasons for denial. In the same report, GAO applauded SSA for successfully reforming its disability denial notices in response to a 1980 Congressional mandate that it "provide more information and personalize" these notices.⁶⁸ In recent years, Medicare Part A denial notices have become more responsive. Beneficiaries now receive a checklist indicating reasons for denial.

In addition, the Medicare Part B Carriers Manual instructs carriers to write review determination letters at the sixth to seventh grade level, and indicates how to establish this reading level.⁶⁹ There is no systematic information available on the success of this effort.

Informal Verbal Denials—Another problem related to the inadequate denial notice is the informal verbal denial. The Vietnam Veterans of America Legal Services, "Self-Help Guide on VA Claims," for example, warns veterans not to be discouraged if, over the phone or at the front desk, a VA employee tells them they are not entitled to benefits.⁷⁰ Advocates for DI and SSI beneficiaries indicate that SSA employees sometimes discourage individuals from applying for benefits.⁷¹

This sort of denial, which does not have the sanction of law in any benefit program, would be difficult

⁵⁹ John A. Sommer, Jr. and Philip R. Wilkerson, conversation with author.

⁶⁰ Recommendation 89-1, Peer Review and Sanctions in the Medicare Program, June 12, 1989.

⁶¹ Carlos Zarabosa, Office of Prepaid Health Care, Health Care Financing Administration, conversation with author (Washington, D.C.: November 27, 1989).

⁶² *Sarrassat v. Sullivan*, C88-201-61 RPA USDC, NDCal. (May 4, 1989).

⁶³ Charles C. Hulin, conversation with author, Alfred Chiplin; National Senior Citizens Law Center, conversation with author (Washington, D.C.: November 13, 1989).

⁶⁴ Alan K. Kaplan, Consultant on Medicare PROs, conversation with author (Washington, D.C.: November 15, 1989).

⁶⁵ Disability Advisory Committee, *Report*, 2.

⁶⁶ Roger W. Shuy, "Changing Language Policy in a Bureaucracy," *Georgetown University Roundtable*: 1987, 152.

⁶⁷ 38 U.S.C., Sec. 3004 (1989).

⁶⁸ General Accounting Office, *Veteran's Benefits: Improvements Needed in Processing Disability Claims* (Washington, D.C.: June 22, 1989).

⁶⁹ Health Care Financing Administration, U.S. Department of Health and Human Services, *Medicare Carriers Manual*, Part 3, Claims Process, Revision 1291, sec. 12010.2, February 1989, 12-15.

⁷⁰ Vietnam Veterans of America Legal Services, *Self-Help Guide on VA Claims*, February 1988, 1.

⁷¹ Eileen Sweeney, conversation with author.

for a beneficiary to prove. Recently enacted legislation allows an eligible beneficiary proving that such a conversation occurred in a DI or SSI case to receive benefits back-dated to the initial inquiry.⁷² Problems raised by providers' verbal denials to beneficiaries, especially in hospital, SNF and home care situations, are discussed in Section V, above.

The Toll-Free Number

Benefit programs have instituted toll free numbers as a means of enabling beneficiaries to make claims-related inquiries, including inquiries about unclear information in notices. According to HCFA, the Medicare Part B 800-number, which is operated by the carriers that process these claims, has had 27.8 million inquiries in the past year, 80 percent of which were claim related.

SSA also has a toll free number for claims inquiries. The number was instituted along with a cut-back of District Office personnel. Critics claim that there is not enough staff to answer all of the phone calls, so that beneficiaries frequently cannot get through to an SSA representative.⁷³

The Veterans' Assistance Service, with a Washington office and several regional offices, receives a large number of calls. It appears to be reasonably effective in providing information about claim and appeal procedures to callers. Beneficiaries' representatives indicate that the information provided may not always be reliable, and suggests that beneficiaries write directly to DVA general and claims related information.⁷⁴

Timeliness of Review

In addition to adequate notice, due process requires expeditious review, particularly when the disputed benefits provide essential living allowances or critical medical care. In practice, all benefit programs have difficulty achieving speedy resolution of disputed claims.

The length of time involved in asserting review and appeal rights in benefit programs from initial claim submission to final agency appellate review may be a substantial disincentive to beneficiaries' pursuit of their review and appeal rights.

Although most agencies provide guidance as to an acceptable length of time to review a case, few require by regulation that the various stages of administrative review be completed within a pre-established time period. Medicare insurance carriers' contracts with HCFA contain numerical targets for processing claims and review requests which are monitored by HCFA.⁷⁵ One negative result of setting quantitative goals and quotas for review of claims has been determinations based on inadequately developed records.⁷⁶ The Disability Advisory Committee recognized that due process rights should not be sacrificed to concerns about processing time.⁷⁷

Despite their sympathy for the need to develop adequate records, beneficiaries' representatives complain that the review process generally takes an inordinate amount of time. Although program statistics bear out the validity of this criticism, there has been little litigation on the subject of timely review in benefit programs.

Benefit Program Performance—Available figures indicate that average processing times for administrative review and appeal can be as long as two years. In the DVA, for example, original claims average 90 to 150 days to process. The average time for a claim to go from initial denial to the final administrative appeal level, the BVA, is about one year.⁷⁸ The BVA takes an average of 151 days to render its decision. The time variations among fiscal intermediaries in reviewing Medicare Part A claims are great. One beneficiary representative reports that some cases take as long as eight months in the initial review stage and an additional two to eight months for reconsideration.⁷⁹

In May 1989, Medicare Part B claims took 224 days from request to ALJ hearing. Medicare Part B cases reaching the ALJ determination level between January 1987 and June 1989 took an average of 154 days from filing to decision for on-the-record reviews and 299 days for in-person hearings. The most time-consuming step in the in-person hearing process was the assignment of cases to analysts in SSA's Development Center, a recently created body that reviews Medicare cases prior to assignment to the ALJ.⁸⁰

DI and SSI cases may take as long as 676 days from filing initial claim request until the ALJ renders

⁷² 42 U.S.C. Sec. 1395u(b)(2)(B).

⁷³ Eileen Sweeney, conversation with author; John A. Sommer Jr. and Philip R. Wilkerson, conversation with author.

⁷⁴ Disability Advisory Committee, *Report*, 7.

⁷⁵ J.H. Spindle and Robert Yurgal, Department of Veterans Affairs, conversation with author (Washington, D.C.: January 6, 1990).

⁷⁶ Charles C. Hulin, telephone conversation with author.

⁷⁷ General Accounting Office, *Medicare. Statistics on the Part B Administrative Law Judge Hearings Process*. (Washington, D.C.: November 1989).

⁷² P.L. 101-239, Sec. 10302, *Congressional Record*, November 21, 1989, H9444.

⁷³ Eileen Sweeney, conversation with author.

⁷⁴ Michael Wildhaber, conversation with author.

a decision. SSA has targeted shortening the length of time for review and appeal a necessary reform.⁸¹

Until recently, the backlog of HMO cases awaiting HCFA reconsideration was substantial, the average case taking one to one-and-a-half years to get through the reconsideration stage. As a result of *Levy v. Bowen*,⁸² however, HCFA has agreed to require HMOs to limit the time allowed for review to up to 60 days after a beneficiary files a request for review. Also, NDG, the organization with which HCFA has contracted to review all HMO denials and make reconsideration decisions, has been working to reduce the backlog of cases. By October 1989, NDG had cleared up all but 21 of the 1988 backlog of 562 cases, in addition to processing about 75 percent of the 1989 cases.⁸³

Circumstances Requiring Speedy Decisionmaking—Because of the importance of rendering a Medicare decision immediately prior to hospital discharge, the PRO review and reconsideration process is designed to move unusually quickly. Under certain circumstances, this decision might be reversed at a later date.

The extended time period for claims decisions often adversely affects providers as well as beneficiaries. Consequently, regarding Medicare Part A SNFs and HHAs, both beneficiaries' advocates and providers have recommended that HCFA develop a mechanism for initial claims determination that, like the PRO process, would be speedy and performed by qualified experts.⁸⁴ An advisory commission on home health care has recommended an expedited appeal to an independent entity at the request of the beneficiary or provider.⁸⁵ This would alleviate concerns about beneficiaries or providers having to expend funds in advance of decisions about reimbursement and enable beneficiaries, their families and providers to make more realistic care-related decisions.

Access to Information on Which Determinations are Based

Determinations denying benefits for reasons related to medical condition or level of care are based on whether the beneficiary's condition is considered as covered within the policies of the benefit program. A beneficiary cannot effectively argue that her/his condition or circumstance is covered by benefit program

policies or criteria unless these are known to the beneficiary. In order to prepare a case adequately, the beneficiary needs access to any information about benefit program criteria or policies that might influence the benefit determination.

Problems in Obtaining Critical Information—Dissatisfaction with the existing level of benefit program accountability to beneficiaries regarding adverse determinations or publication of policies that might adversely affect beneficiaries is widespread. Critical information frequently unavailable to beneficiaries and their representatives or difficult to obtain includes:

- basic manuals containing detailed operating instructions for claims examiners and reviewers
- screens and other criteria used to eliminate beneficiaries with certain types of conditions or situations from consideration for benefits
- internal program guidelines or informal directives to individuals making or reviewing claims determinations
- major program-wide decisions that have the effect of general policy statements, but are not offered for public comment prior to implementation

Although all benefit programs have been criticized to some degree for inaccessibility of critical information, Medicare appears to be the most problematic. In part, this may be because of the wide latitude given contractors to interpret Medicare rules in the review and appeals process. In addition, the decentralized administration of the Medicare program gives rise to inconsistent interpretations of policies and directives, and makes careful monitoring of the day-to-day aspects of the review and appeal process virtually impossible.

Program Rationale for Limiting Access to Information—The Administrative Procedure Act⁸⁶ requires federal administrative agencies to ensure that: the public be given an opportunity to comment on proposed rules; the agency consider the comments; and final rules be published prior to implementation. The purpose of this provision is to encourage public participation and fairness to parties affected by the proposed rules, and to increase public acceptance of the validity of the new policies.⁸⁷

The Administrative Conference of the United States has consistently urged HHS to provide greater opportunity for public comment on its policies for

⁸¹ Disability Advisory Committee, *Report*, 2.

⁸² CD CA, June 20, 1989.

⁸³ Sylvia Hendel, conversation with author.

⁸⁴ Charles C. Hulin, conversation with author; Susan Pettey, conversation with author.

⁸⁵ Advisory Committee on Medicare Home Health Care, *Report to Congress and Health Care Financing Administration*, July 1, 1989.

⁸⁶ 5 U.S.C., Sec. 553.

⁸⁷ T.S. Jost, "Administrative Law Issues Involving Medicare Utilization and Quality Control PRO Program: Analysis and Recommendation," *Ohio State Law Journal*, 50, (1) (1989): 10.

making coverage and payment determinations.⁸⁸ The rationale of benefit programs for resorting instead to manual transmittals, program instructions and contracts that are not made available to the general public, may be that the Administrative Procedure Act rulemaking procedures have become too burdensome and time-consuming for programs with rapidly changing needs and circumstances. The legal justification for by-passing this statute is that technically its language does not encompass these types of materials.⁸⁹

Recent Case Law—A number of cases examine issues relating to the promulgation of manuals and other limited circulation materials used in making claims-related decisions. Through these decisions the courts may be imposing a kind of accountability on benefit programs.

Reliance on Unpublished Policies—In *Duggan v. Bowen*,⁹⁰ the court found that the Medicare program had promulgated a policy by letter, the effect of which was to limit reimbursement for part-time or intermittent home care under Part A. The policy itself violated the Medicare Act and the manner of its promulgation violated the Administrative Procedure Act. HCFA had minimal regulations addressing the provision of part-time or intermittent care. Instead it relied on policy statements found in manuals and transmittals, none of which had been subject to public notice and comment.

The court pointed out that ALJs, placing more weight on the statute and regulations than on internal directives, have ruled that Medicare should provide coverage in the type of situation litigated in this case.

In response to the decision in *Duggan v. Bowen*, HCFA, in consultation with the National Association for Home Care, has revised its manual of directives to fiscal intermediaries to amend and clarify its policy regarding payment for part-time or intermittent care.⁹¹

"Rules of Thumb"—Courts also have criticized PROs for using arbitrary "rules of thumb" to deny benefits when HCFA's published bulletin for PROs required individualized assessments of each patient's needs in determining eligibility. In *Hooper v. Bowen*,⁹² the court indicated that a particular guideline was not meant to create an irrebutable presumption of noncoverage, but merely to indicate the possibility of noncoverage. In all cases where denial is possible, PRO physicians are expected to consider the indi-

vidual facts and circumstances of the patient's medical condition and grant coverage whenever hospitalization is medically necessary.

The illegality of "rules of thumb" were at issue in *Fox v. Bowen*,⁹³ a case in which a fiscal intermediary denied benefits based on blanket unpublished rules not authorized by statute or regulation. The court forbade fiscal intermediaries and providers from making decisions about beneficiary eligibility for Medicare benefits based on arbitrary rules of thumb. The fact that employees of the fiscal intermediary were available to discuss individual coverage decisions with the beneficiary's service provider did not amount to an individual assessment of the beneficiary's case.

Utilization Screens—When HCFA required a carrier to develop utilization screens for Medicare Part B claims, the court reiterated that screens should be used only as guides, and were not to preclude individual assessment of the beneficiary's condition.⁹⁴

Secret Directives—Sometimes benefit programs base claims determinations on unpublished policies or criteria. In *Bowen v. City of New York*,⁹⁵ the Supreme Court held that DI and SSI recipients were denied due process when a state agency denial of benefit claims was based on an unpublished policy contrary to published SSA policy. The policy had never appeared in the Federal Register, but was implemented through internal memoranda and other bureaucratic devices.

The Court said that failure to make the policy, which went to the heart of disability determinations, known to beneficiaries denied them a fair decision. The Court made it clear, however, that benefit programs cannot be expected to publish every directive which may affect benefit determinations.

In addition to violating the Constitution, initial determinations based on secret sources impose unnecessary burdens on appellate level decisionmakers and additional expense on the review and appeal system. For example, in DI, SSI and Medicare cases, where ALJs are required to make decisions based solely on law and regulations, reversal of denials justified on any other grounds is virtually inevitable. One ALJ stated that reliance on secret sources for lower level decisionmaking requires the ALJ to do two jobs—her/his own and that of the earlier decisionmaker.⁹⁶

⁸⁸ E.g. Recommendation 89-1, June 12, 1989.

⁸⁹ T.S. Jost, "Administrative Law Issues," 10.

⁹⁰ 691 F.Supp. 1487 (D.D.C. 1988).

⁹¹ T.S. Jost, "Administrative Law Issues," 10.

⁹² U.S.D.C., D CT, July 20, 1989.

⁹³ 656 F.Supp. 1236 (DCT 1987).

⁹⁴ *Vorster v. Bowen*, 709 F.Supp. 934 (CDCal. (1989)).

⁹⁵ 476 U.S. 467 (1985).

⁹⁶ Ronald G. Bernoski, Secretary, Association of Administrative Law Judges, telephone conversation with author, January 4, 1990.

For beneficiaries who accept determinations of denial without further question, the result of a denial based on secret sources could be devastating.

Congressional and Administrative Action—Congress has expressed a commitment to the importance of providing for public comment on major benefit program policy statements and administrative directives. In 1987, Congress enacted certain provisions requiring HCFA to publicize more of its policies governing Medicare. For example, HCFA must promulgate substantive program rules, policies, requirements, and changes in the scope of benefits, or beneficiary eligibility as regulations.⁹⁷ As regulations, these will require a request for public notice and comment.⁹⁸

In addition, the statute requires the publication and regular updating of a list of all manual instructions, guidelines of general applicability, interpretative rules, and statements of policy that have not been promulgated as regulations.⁹⁹ Also, the contractual relationship between HCFA and private organizations to which it has delegated claims determination, and review and appeal functions continues to result in exempting many significant substantive policies and directives from the requirement of public scrutiny. The rationale is that the Administrative Procedure Act does not apply to the internal workings of these organizations.¹⁰⁰

Medicare Home Health Care Denials—A Case Study—During FYs 1986 and 1987, there was a dramatic increase in the number of denials of Medicare home health care claims. Responding to numerous complaints from home health care providers, physicians and senior citizen groups, Congress, in the Medicare Catastrophic Coverage Act of 1988, mandated the creation of an Advisory Committee on Medicare Home Health Care to determine the reasons for the denials and to recommend reforms to Congress and HCFA. Among the findings of the committee were several relating to the impact of HCFA's reliance on informal communication of policies and program directives, and to the decentralization of decisionmaking on the Medicare Part A claims, review and appeal processes.¹⁰¹

The committee indicated that even the attempt to collect documentation necessary to implement policy and program changes often was futile because very little of the critical information was recorded in any

manner.¹⁰² The frequent changes in HCFA policy regarding payment of home health care claims generally were communicated to fiscal intermediaries responsible for claims payment decisions as instructions or informal directives.¹⁰³

The committee also found considerable inconsistency among fiscal intermediaries in the manner of processing, reviewing and denying claims, and in the application of Medicare coverage criteria. When fiscal intermediaries initiated new coverage criteria that resulted in an increase of claims denied, they failed to provide prior notification to providers.¹⁰⁴

The committee made several recommendations to Congress and HCFA regarding claims review and appeal decisions. Two that relate to improving communication regarding the reasoning behind benefit-related decisions are that there should be:

- Advance written notice and an opportunity to comment before proposed program and policy changes are implemented and
- Prospective and timely dissemination of policies or related communications; policies should not be subject to regional [HCFA] interpretation prior to dissemination¹⁰⁵

Right to a Determination Based on an Adequate Record

Files containing inadequate information about the validity of beneficiaries' claims (records) offer significant basis for reversal of claims determinations in many benefit programs and are probably the major reason for delay in the review and appeal process. Records may be inadequate because established procedures for developing medical, functional or other relevant information about beneficiaries are deficient. When procedures themselves are acceptable, personnel may not be adequately trained or monitored, or provided with appropriate work incentives.

Benefit Program Practices—The Constitution requires benefit programs to base determinations on accurate, complete and timely information. The rate of reversals on appeal indicates, however, that in the earlier stages of review, programs frequently do not develop records that meet this standard. Because most beneficiaries do not appeal claims determinations at all, and a declining number appeal them at each stage of the review and appeal process, many beneficiaries

⁹⁷ 42 U.S.C., Sec. 1395hh(a)(2).

⁹⁸ 42 U.S.C., Sec. 1395hh(b)(1).

⁹⁹ 42 U.S.C., Sec. 1395hh(c)(1).

¹⁰⁰ See, e.g., *American Hospital Association v. Bowen*, 834 F.2d 1037 (D.C. Cir. 1987), re protection of HHS from obligation to seek comment on policies embodied in contracts with PROs.

¹⁰¹ Advisory Committee on Medicare Home Health Care, *Report* 10-12.

¹⁰² Advisory Committee on Medicare Home Health Care, *Report* 22.

¹⁰³ Advisory Committee on Medicare Home Health Care, *Report* 49.

¹⁰⁴ Advisory Committee on Medicare Home Health Care, *Report* 64.

¹⁰⁵ Advisory Committee on Medicare Home Health Care, *Report* 12.

are receiving determinations based on inadequate information about their claims. Practices of benefit programs illustrate some systemic problems resulting from adequate claims records.

Department of Veterans Affairs—Beneficiaries’ representatives complain that the initial claims determination process within DVA is deficient because the records on which the Rating Board makes its decisions frequently are incomplete. For example, DVA staff may not order medical examinations as part of the initial process, so that these must be ordered at later stages. In addition, unrepresented veterans frequently do not assert their claims beyond initial denial, and so are inadequately served by the system.¹⁰⁶

Another obstacle to developing adequate records for DVA disability proceedings is the difficulty in getting medical records from the various medical installations of DVA where beneficiaries are examined and treated.¹⁰⁷

Social Security Administration—Witnesses testifying before an SSA committee on disability claims stated that SSA personnel are not sufficiently active in initial development of claims records. They also criticized SSA staff for not communicating effectively with beneficiaries, particularly those who do not speak English, about the evidence required to prove their claims. The Committee recommended that SSA affirmatively assist beneficiaries by insuring pursuit of every appropriate method of securing evidence to support their claims.¹⁰⁸

Other testimony alleged that, because claims development standards are lacking, there is no uniformity in decisionmaking by state DDSs. Records at the DDS level may be problematic because of: inappropriate medical evidence, incomplete evidence, failure of staff to follow up on acquiring requested evidence, and poor quality evidence. The Committee recommended that SSA standardize requirements for a complete record and hold state level employees responsible for complying with these requirements.¹⁰⁹

Another concern is the appropriateness of the evidence gathered for the record. Beneficiaries’ representatives criticize the heavy reliance on traditional medical evidence and physicians’ opinions in DI and SSI determinations.¹¹⁰ Even though the effects of

chronic disability are observed most frequently by family members, nurses or personal care attendants, SSA regulations indicate that only physician information is acceptable as medical information about beneficiaries.¹¹¹

Medicare—Problems of adequacy of claims records in Medicare are more difficult to evaluate. Much of the evidence on which determinations are based is technical in nature. In addition, HCFA has little direct control over the initial claims process and the early stages of review. NDG, the contractor providing reconsideration decisions in HMO cases, has indicated to HCFA that the principal reason for delays in making these determinations has been the need to go back to the HMOs for additional material in order to complete claims records.¹¹²

Right to Make a Verbal Statement or Argument in Front of the Decisionmaker

Both beneficiaries’ advocates and benefit program administrators believe that face-to-face communication of some sort between beneficiaries and decisionmakers as early as possible in the review and appeals process would be efficacious.¹¹³ Some believe that if beneficiaries are given an early opportunity to present their side of the story directly to decisionmakers, their levels of satisfaction even with adverse decisions, would rise substantially.¹¹⁴ Other results might be fewer appeals and less strain on benefit program administrative apparatus. Although viewing a beneficiary in the flesh may on occasion have a negative impact on a decisionmaker, in-person hearings are known to improve vastly beneficiaries’ chances for favorable determinations. In Medicare Part B ALJ determinations, for example, beneficiaries choosing on-the-record reviews received favorable decisions in 26 percent of the cases, while those choosing in-person hearings received favorable decisions in 40 percent.¹¹⁵

In-Person Reviews in Benefit Programs—The availability of in-person administrative reviews is built into all benefit programs, although the stage in the process at which they occur, and the formality of the proceedings, vary. These reviews are not automatic, but must be requested by the beneficiary. Generally, the time span is significantly longer for in-person hearings

¹⁰⁶ John A. Sommer Jr. and Philip R. Wilkerson, conversation with author.

¹⁰⁷ J.H. Spindle, Jr. and Robert Yurgal, conversation with author; John A. Sommer Jr. and Philip R. Wilkerson, conversation with author.

¹⁰⁸ Disability Advisory Committee, *Report*, 9.

¹⁰⁹ Disability Advisory Committee, *Report*, 9.

¹¹⁰ Eileen Sweeney, conversation with author; Ayn Crawley, conversation with author.

¹¹¹ 20 CFR 404.1513.

¹¹² Carlos Zarabosa, conversation with author.

¹¹³ Jean Hinckley, conversation with author; Michael Parks, telephone conversation with author; Eileen Sweeney, conversation with author, Disability Advisory Committee, *Report*, 18.

¹¹⁴ Jean Hinckley, conversation with author; Ayn Crawley, conversation with author.

¹¹⁵ General Accounting Office, *Part B Hearings Process*.

than on-the-record reviews; also the expense to all parties is greater.

All benefit programs provide the opportunity for hearing at the final level of appeal within the agency, but this may be contingent on the amount in controversy. For all of the HHS programs, in-person hearings occur the ALJ level. For DVA, they are before the BVA. Medicare Part B procedures provide, as well, for a carrier fair hearing at the reconsideration level; Medicare HMOs at the initial review level; DVA for hearings at all stages; and SSA for a hearing prior to termination, for DI beneficiaries only.

Despite the generally acknowledged value of the in-person hearing, few beneficiaries take advantage of it. Although, in DI and SSI cases, 90 percent of ALJ proceedings are in-person hearings,¹¹⁶ this is unusual among benefit programs.

The HCFA Carriers Manual indicates that carrier staff should explain to beneficiaries requesting a carrier reconsideration that, although they are entitled to an in-person hearing, an on-the-record decision based on a full review of the record is faster and less costly.¹¹⁷ Beneficiaries' representatives indicate that other agencies may direct staff to encourage beneficiaries to select on-the-record hearings for similar reasons.¹¹⁸ In DVA programs, for example, although hearings are available at all stages, relatively few actually are held. Hearings before the BVA take place in Washington, D.C., and veterans must appear at their own expense. BVA traveling panels are infrequent, thereby delaying the appeal process significantly.

Recently DVA, pursuant to a consent decree, established an intermediate level panel of hearing officers that hear cases at the regional offices. These hearing officers cannot have participated in the initial decision.¹¹⁹ This should increase the number of hearings held. DVA, however, is not currently publicizing the availability of this opportunity.¹²⁰

Involving the Decisionmaker—It is essential that early in-person communication between beneficiaries and benefit programs as part of the review and appeal process involve the decisionmaker or all members of a decisionmaking team.¹²¹ This communication need

not be in the context of a formal hearing. It might be a prehearing conference as suggested by the Disability Advisory Committee¹²² or an interview as part of the initial review process, as recommended by the Administrative Conference.¹²³

Impact of Face-to-Face Interviews—A recent GAO study determined that the face-to-face interviews that ALJs conduct with DI and SSI beneficiaries are major factors in reversal of DDS denials in on-the-record reconsiderations. At the time of the study, ALJs were reversing DDS decisions in over 60 percent of cases receiving an ALJ hearing. For several categories of beneficiaries the rate was between 70 and 100 percent.¹²⁴ GAO recommended that the Secretary of HHS direct SSA to initiate a demonstration project that would include face-to-face interviews for selected beneficiaries at the reconsideration stage. The purpose of the recommendation was to allow DDSs to approve some claims that would otherwise be approved by ALJs, and to better document DDS decisions later reviewed by ALJs.¹²⁵

The Disability Advisory Committee has identified the absence of face-to-face communication between beneficiaries and decisionmakers as a significant factor undermining the effectiveness of the hearing and appeal process in SSA. It has recommended more involvement between DDSs and beneficiaries in preparing claims files for initial review, and face-to-face hearings at reconsideration.¹²⁶ The Committee stated that "it is not enough that individuals receive 'fair' decisions," and urged that SSA "endeavor to ensure that applicants also view these decisions as fair and proper based on the evidence."¹²⁷

Telephone Hearings—The use of high technology that lowers costs and also satisfies frail or disabled beneficiaries is an inevitable outgrowth of a legitimate search for ways to provide fair hearings and also contain the costs of administering large scale benefit programs. Beneficiaries' advocates and administrators caution against heavy reliance on using the telephone as an alternative to in-person hearings. They contend that, even though it may be difficult for chronically disabled, ill or elderly individuals to get to the hearing location, the advantages of the in-person hearing outweigh the difficulties.¹²⁸

¹²² Disability Advisory Committee, *Report*, 18.

¹²³ Frank S. Bloch, *Report and Recommendations on the Social Security Administration's Administrative Appeal's Process* (Administrative Conference of the United States, 1989), 130.

¹²⁴ General Accounting Office, *Social Security/Selective Face-to-Face Interviews with Disability Claimants Could Reduce Appeals*, (Washington, D.C.: April 1989), 3.

¹²⁵ General Accounting Office, *Face-to-Face Interviews*, 3-4.

¹²⁶ Disability Advisory Committee, *Report*, 10.

¹²⁷ Disability Advisory Committee, *Report*, 8.

¹²⁸ Eileen Sweeney, conversation with author; Jean Hinckley, conversation with author.

¹¹⁶ Jean Hinckley, conversation with author.

¹¹⁷ *Medicare Carriers Manual*, Part 3, Claims Process, Revision 1291, sec. 12105, February 1989, 12-21.

¹¹⁸ Eileen Sweeney, conversation with author.

¹¹⁹ *Semenchuk v. Walters*, No. 84-C-312, U.S.D.Ct., ND ILL (March 18, 1985).

¹²⁰ John A. Sommer Jr. and Philip R. Wilkerson, conversation with author.

¹²¹ Jean Hinckley, conversation with author; Ayn Crawley, conversation with author.

Congressional and Administration Interest—In the Omnibus Budget Reconciliation Act of 1987,¹²⁹ Congress raised the question of whether telephone hearings can be conducted effectively and efficiently in a Medicare environment. Medicare beneficiaries continue to have the option to select telephone hearings at the carrier level. These must be conducted according to specific procedures set out in the Medicare Carriers Manual.¹³⁰

The Inspector General of HHS has studied the legality and viability of expanding telephone hearings to the ALJ level and has concluded that such hearings are legal, provided they employ adequate safeguards of due process. Furthermore, the Inspector General found that: the Medicare Part B telephone hearings complied with due process; beneficiaries using these hearings generally perceived them to be fair; and, most Medicare issues could be handled effectively by telephone.¹³¹

Reasons for Concern—Critics of providing telephone hearings for the population generally served by benefit programs agree that these should be an option for individuals who prefer the telephone, but stress that, without an in-person hearing, the decisionmaker cannot see the beneficiary's demeanor. In addition, they describe the average beneficiary, particularly of DI or SSI, as unused to high technology and probably frightened of it.¹³² Others suggest that telephone hearings might be appropriate if the advocate and the decisionmaker communicate without the beneficiary's participation in the conversation.

Linguistic studies of the different impacts of face-to-face and telephone communication, indicate that, in virtually all instances, face-to-face conversation provides the parties with vastly more effective and comprehensible communication. This is because face-to-face communication involves more clues to meaning than just speech. Gestures, eye gaze, body orientation, and touching are all available to individuals engaged in face-to-face conversation. These findings indicate that trained administrators with experience in using telephones for business have a distinct advantage over beneficiaries, most of whom do not possess this skill. In congressional testimony, the Chairman of the Georgetown University Department of Linguistics listed the essential characteristics of ef-

fective administrative adjudicatory hearings, conducted by telephone as:

- the ability of both parties to be as explicit verbally as they normally would be in face-to-face dialogue
- the necessity that both parties speak so that all jargon, dialect, age and gender differences are removed
- recognition that elderly beneficiaries may be hard-of-hearing
- the ability of both parties to maintain the same style of language—consultative, formal or casual
- the necessity that both parties are equally at ease with the culture of the telephone.

His testimony continued with the thought that this type of hearing becomes more complex with each additional participant in the telephone hearing.¹³³

Right to a Hearing Prior to Denial or Termination of Benefit

The law regarding termination of benefits without a hearing bears directly on who pays during the period of adjudication of the validity of an outstanding claim. Under the facts of *Mathews v. Eldridge*¹³⁴ the beneficiary pays. Under *Goldberg v. Kelly*¹³⁵ the government pays. Under Medicare Part A, the provider pays. Until recently changed by legislation, when a recipient of DI was terminated from benefits, an on-the-record review was considered sufficient so long as a hearing was available within a reasonable amount of time after termination. The Supreme Court's justification for this holding was that DI recipients generally are terminated from benefits because they are able to return to work.¹³⁶ Consequently, their reliance on the DI benefit is not as great as a welfare recipient's reliance on public benefits.

In more recent cases, courts have been drawing distinctions. In *Martinez v. Bowen*,¹³⁷ for example, the District Court found that Medicare beneficiaries were entitled to a pretermination hearing and to continued receipt of benefits until a determination was made. Its rationale was that as part of a class disadvantaged by disability, illness and poverty, these beneficiaries were more like welfare than DI recipients. Medicare provided them with the means to live while hearings

¹²⁹ Office of Inspector General, U.S. Department of Health and Human Services, *Appeals by Telephone: Appellant Reactions and Implications for Appeals Processing* (U.S. Department of Health and Human Services, June 1988), ii.

¹³⁰ *Medicare Carriers Manual*, Part 3, Claims Process, Revision 1291, sec. 12017, February 1989, 12-33.

¹³¹ Office of Inspector General, *Appeals by Telephone*.

¹³² Eileen Sweeney, conversation with author; Jean Hinckley, conversation with author.

¹³³ Testimony of Roger W. Shuy, Ph.D., Georgetown University, before the U.S. Senate Committee on Governmental Affairs, June 1988.

¹³⁴ *Mathews v. Eldridge*, 424 U.S. 319 (1975).

¹³⁵ *Goldberg v. Kelly*, 397 U.S. 259 (1969).

¹³⁶ *Mathews v. Eldridge*, 424 U.S. 319 (1975).

¹³⁷ *Martinez v. Bowen*, 655 F.Supp. 95 (DCNM, 1986).

were pending.¹³⁸ Several benefit programs have regulations protecting beneficiaries during the pendency of a benefit termination proceeding. Under current law, DI and SSI beneficiaries receive payment during the pendency of a termination hearing through the ALJ hearing stage. If the beneficiary is denied, overpayment of benefits are supposed to be returned. As a matter of program practice, this rule is rarely enforced. DVA permits a beneficiary receiving termination notice 60 days to appeal before benefits are cut off.

Right to a Determination by an Impartial Decisionmaker

The separation of the review and appeal determination from benefit program influence is a critical aspect of due process that has posed dilemmas for benefit programs. Programs provide for impartial determinations in various ways, some of which are more effective in achieving objectivity and independence from the program than others. All benefit programs, for example, require reconsideration decisions or second-level reviews to be done by individuals not involved in the initial decision or first-level review. The relationship of the reviewers themselves to the program may, however, be problematic.

The implementation of an independent decisionmaking function within benefit programs raises many issues. This section examines three issues that have arisen in the context of specific programs—the independence of the institution of the ALJ within SSA; the use of private contractors to make review and appeal determinations on behalf of Medicare; and, the creation of a Court of Veterans Appeals independent of DVA.

The Independence of the ALJ—The Administrative Procedure Act mandates the independence of ALJs in making benefit-related decisions. Recognizing this, ALJs stress the importance of benefit programs' respecting their professionalism and objectivity. The programs, concerned about containing costs of both benefit payments and the review and appeal process, sometimes institute policies or practices perceived as violating the intent of the Administrative Procedure Act. In recent years, the status of the ALJ within SSA has been the subject of congressional concern among beneficiaries' representatives, GAO, expert commissions and the ALJs themselves. Legislation currently being considered in Congress would either separate the office of ALJ from SSA and HHS entirely by creating an independent ALJ commission

(HR 791), or establish an Office of Chief ALJ that would report directly to the Secretary of HHS (S. 1571).

Related legislation proposing the separation of SSA from HHS also has spurred the movement toward establishing an independent office of ALJ. Critics fear that if SSA is no longer in HHS, SSA's power over the office of the ALJ would be even greater than at present. Another concern is that HCFA, which is required to use SSA ALJs to perform appellate hearings and reviews for Medicare, would seize the opportunity created by the separation of SSA to establish an office of ALJ within its own agency.

Because ALJs function within the administrative rather than the judicial sphere, there is inherent tension between them and the agencies they serve about the limits of their authority to render appellate decisions. The legislative proposals would establish institutional distance between the ALJ and SSA or HCFA. The proposals are motivated by concern about documented practices of these agencies whose result has been, or could be, to restrict the ALJs' abilities to function as independent decisionmakers.

Within SSA and HCFA, past and current policies and practices and the complaints made about them include:

- Establishing a "pool" system to staff the ALJ office so that attorneys and paralegals preparing cases no longer report directly to the ALJ but to the management of SSA, thereby making ALJs accountable for decisionmaking but removing from them the authority over critical aspects of the appeal process ¹³⁹
- Designating certain ALJs to manage other ALJs and supervise the manner in which they process cases, a function not protected by the Administrative Procedure Act ¹⁴⁰
- Instituting individual performance reviews of ALJs, focused on rates of reversal of lower level denials, followed by attempts to modify certain ALJs' behavior or taking punitive measures against them ¹⁴¹
- Not enforcing strict requirements that ALJs take cases on a rotational basis, as required by the Administrative Procedure Act, with the result that it becomes possible for SSA to select judges to hear certain cases ¹⁴²

¹³⁹ Association of Administrative Law Judges, Inc., Statement to the Disability Advisory Committee, Social Security Administration, May 1, 1989.

¹⁴⁰ Association of Administrative Law Judges, Inc., Statement.

¹⁴¹ Association of Administrative Law Judges, Inc., Statement.

¹⁴² Association of Administrative Law Judges, Inc., Statement.

¹³⁸ *Martinez v. Bowen*, 655 F.Supp. 95 (DNM, 1986).

- Limiting the number of ALJs that hear Medicare Part B appeals to selected individuals, resulting in creating administratively a corps of HCFA ALJs that Congress has expressly refused to establish legislatively ¹⁴³
- Countenancing the issuance of *ex parte* directives to ALJs that effectively instruct them as to how to decide a case ¹⁴⁴
- Attempting to influence the already overburdened SSA Appeals Council to review ALJ reversals of lower level denials in Medicare cases, in direct conflict with the law that authorizes the Appeals Council only to take cases appealed by beneficiaries or on its own initiative ¹⁴⁵

Whether or not SSA's or HCFA's reasons for instituting the policies and practices described are as attributed to them by critics, the pervasive complaints call into question the effectiveness of the ALJ system as it currently functions.

Delegation of Review Functions in Medicare—The legality and appropriateness of delegating constitutionally required review and appeal functions to private organizations is controversial. Medicare's delegation of all of the review and reconsideration functions of its various benefit programs to private sector organizations raises important questions about independence of the review process. Each of these private organizations is accountable to HCFA for its performance. Although the Supreme Court has found that such arrangements are not per se violations of due process, it has indicated that an actual conflict of interest will result in unconstitutional determinations. ¹⁴⁶

Medicare Parts A and B—The carriers and fiscal intermediaries that perform reviews and reconsiderations under Parts A and B function as agents of HCFA. They do not themselves provide health care services or benefits to Medicare beneficiaries that would conflict with their ability to make fair decisions about Medicare claims. But through their contracts with Medicare, they could be subject to inappropriate influence. For example, the contracts contain provisions that authorize Medicare to evaluate the effectiveness of carrier or fiscal intermediary review and appeal procedures. The criteria against which the evaluation is made, however, are not readily accessible to public scrutiny. What constitutes "good performance" from the program's point of view is not

generally known. Contractual or informal performance quotas or goals, or more subtle means of directing the outcomes of benefit determinations, are difficult for beneficiaries' representatives to monitor. But failure to pass a quality review of performance under the contract subjects the contractor to possible discontinuance of the contractual relationship.

The independence of the PROs has been challenged for different reasons. Some critics consider that it is difficult for physicians to evaluate fairly the medical decisions of other physicians for fear that their own judgment may be similarly challenged at some future time. ¹⁴⁷ Others consider that the PROs cannot be objective because they are paid by Medicare, and that HCFA might put pressure on physicians to increase the number of claims denials. ¹⁴⁸

Medicare HMOs—The role of HMOs in Medicare review determinations could become particularly problematic. HMOs providing health care services to beneficiaries are authorized to make claims decisions and could contain costs by denying legitimate claims, particularly where these are marginal. Beneficiaries could perceive review by the same organization, even if done by individuals not involved in the initial decision, as unfair. HCFA has given HMOs substantial latitude in developing their own review and appeal procedures, and does not maintain statistics on requests for HMO review or on their rates of denial and allowance of initial claims. ¹⁴⁹ Recognizing the potential for conflict of interest, HCFA regulations require that all HMO reconsiderations resulting in denial of claims must be forwarded to HCFA for review. ¹⁵⁰

The Creation of the Court of Veterans Appeals—Review and appeal procedures functioning entirely within the benefit program or its parent agency may not adequately insure independent decisionmaking regarding benefits. Provision of some sort of judicial review of most actions of administrative agencies is accepted as required by the constitutional separation of powers doctrine.

Until recently, DVA and its predecessor, the Veterans Administration, had not provided for judicial review of benefit decisions. In 1988, after a decade of debate, Congress enacted the Veterans' Judicial Review Act, ¹⁵¹ authorizing the establishment of an independent court, the Court of Veterans Appeals, to review decisions of BVA. Prior to that time, beneficiaries of veterans' benefits could only appeal denials

¹⁴³ Plaintiff's Motion for Injunction and Declaratory Relief, *Kitick v. Sullivan* (Civil Action No. N89-494, U.S.D.Ct., D CT, October 4, 1989).

¹⁴⁴ Plaintiff's Motion for Injunction and Declaratory Relief, *Kitick v. Sullivan*.

¹⁴⁵ *Congressional Record*, Statement of Sen. David Pryor, 101st Cong., 1st Sess., 135 (109), part II, August 4, 1989.

¹⁴⁶ *Schweiker v. McClure*, 456 U.S. 188 (1982).

¹⁴⁷ Richard Husk, perception referred to in conversation with author.

¹⁴⁸ Alan K. Kaplan, perception referred to in conversation with author (Washington, D.C.: November 15, 1989).

¹⁴⁹ Carlos Zarabosa, conversation with author.

¹⁵⁰ 42 CFR 417.620(b)(2).

¹⁵¹ 38 U.S.C., Sec. 4063, *et seq.*

within DVA.¹⁵² Unlike DI benefits which have always been considered entitlements to those who are eligible, until recently, veterans' benefits were considered discretionary. Consequently, Congress was under no obligation to establish judicial review of DVA actions. In 1981, DVA's General Counsel wrote an opinion stating that "benefits are gratuities bestowed by the Government under whatever conditions it chooses to impose."¹⁵³

BVA, the final administrative appeals body, had no external checks on its actions. If BVA chose not to resolve a difficult issue or decide a complicated case, there was no effective means of forcing it to do so. At the same time, it was, and still is, considered subject to pressure from DVA regarding decisions in politically controversial cases.¹⁵⁴ Some beneficiary representatives argue that, even with the creation of the court, veterans continue to be denied truly independent determinations at the agency level.¹⁵⁵ Prior to the enactment of the Veterans' Judicial Review Act, the American Legion lobbied for many years for the creation of an administrative appeal body totally independent of DVA, to replace the existing placement of BVA within DVA.

The Court of Veterans Appeals was established with the expectation that it would provide an independent perspective on decisionmaking in DVA programs including disability benefits. It is too soon to speculate about its possible impact on the quality of benefit-related decisionmaking at all levels within DVA. Other recent legislation as well and court intervention may result in substantial changes in DVA review and appeal practices.¹⁵⁶

WHAT ARE THE SIGNIFICANT LESSONS FOR A NEW LONG-TERM CARE BENEFIT PROGRAM IN THE EXPERIENCE OF EXISTING BENEFIT PROGRAMS?

This section summarizes the report. The summary is organized around three basic assumptions about the importance of providing due process in benefit programs. Under each assumption, the report identifies

the relevant lessons learned from the experience of existing benefit programs, and discusses their implications for a long-term care program.

ASSUMPTION: A benefit program's review and appeal procedures cannot provide adequate due process unless policies about the programs themselves support fair decisionmaking.

Lesson: The Type of Benefit, Sources of Financing and Structure of Administration of Benefit Programs

1. The type of benefit provided (periodic payments or payments tied to services performed), the urgency to beneficiaries of eligibility or coverage determinations, and the type of evidence available to the claims decisionmaker (e.g. technical, anecdotal or state of mind evidence) all affect the way in which a benefit program constructs its review and appeal procedures.

When benefit program administrators have adequate time and information available for considered decisionmaking, an opportunity exists to ensure fair initial coverage and eligibility determinations. For various reasons such as the priority of cost containment or the complexity of administration, benefit programs do not always take advantage of this opportunity. Benefit programs that constantly deal with acute care needs have difficulty making initial eligibility determinations both rapidly and fairly.

Historically, benefit programs paying periodic benefits over a long term (DI, SSI, DVA) have developed review and appeal procedures that are reasonably accessible to beneficiaries. The procedures of programs that pay benefits based on specific services either to providers or beneficiaries (Medicare) have been less accessible, possibly because the high volume of claims coupled with the relatively low amount of payment to each beneficiary makes such procedures appear to be unjustifiably costly.

2. The sources of financing and structure of administration of benefit programs have an impact on the development of review and appeal procedures. In addition to meeting certain constitutional standards, programs that are both financed and administered by the federal government are subject to federal legislation in establishing review and appeal procedures. State financed or administered programs develop procedures under state law. Privately financed programs do not have due process obligations. Federally financed programs administered by private organizations may have

¹⁵² See Barton F. Stichman, "Overview of the Veterans Judicial Review Act," *Administrative Law Review*, 41, 3, (Summer 1989): 365-397, for a general discussion of the Court of Veterans Appeals.

¹⁵³ See Frank S. Bloch, "Federal Disability Law and Practice, 1984," *Symposium on Federal Disability Benefit Programs* (American Bar Association, 1984) 159.

¹⁵⁴ See Frank S. Bloch, "Federal Disability Law," 159, Sec. 6.1.

¹⁵⁵ Michael Wildhaber, conversation with author; John A. Sommer Jr. and Philip R. Wilkerson, conversation with author.

¹⁵⁶ See Michael E. Wildhaber, et. al., *Veterans Benefits. Representing Veterans Under the New Veterans Judicial Review Act*, section on administrative review provisions, 9-17, 1989.

differing due process requirements depending on the legal relationship between the private organization and the federal program.

Implications for a New Long-Term Care Program— Policymakers developing a long-term care program are sensitive to the different legal and political realities of alternative program models. Similar awareness that review and appeal procedures are integrally related to program policies and practices is critical to developing procedures that can be effectively implemented. If a long-term care program is placed under the administration of an existing benefit program, this program's review and appeal procedures are likely to be applied to the new program. If the existing program's procedures are problematic, the long-term care program's procedures also are likely to be problematic.

Policy decisions about the manner in which benefit programs are financed, administered or operated on a day-to-day basis are closely related to the review and appeal procedures for these programs. Consequently, if these procedures are to be fair, certain types of decisions about the underlying program cannot be formulated without consideration of their implications for due process.

ASSUMPTION: Review and appeal procedures that meet constitutional due process standards are essential to fair benefit-related determinations.

Constitutional due process provides a mechanism for fair determination of benefit entitlement. In so doing, it provides a mechanism for fair determination of nonentitlement.

Lesson: Cost Containment

1. When beneficiaries' claims for benefits have significantly outstripped available funding, program administrators sometimes have responded by increasing the number of initial claims denials. Assertive individuals or organizations believing that beneficiaries were legally entitled to receive these benefits, have protested the benefit denials administratively, in court or to Congress.

2. The implementation of review and appeal procedures that meet statutory and constitutional due process standards is expensive. In planning for benefit programs and calculating their cost, policymakers have not taken sufficient account of the cost of review and appeal procedures, even though these are required by law.

Benefit programs, chronically strapped for funds, frequently resort to cost-cutting shortcuts in administering review and appeal processes. Consequently, they may countenance policies and practices that do not meet constitutional and statutory standards for due process, or that are subject to controversy itself expensive to resolve.

As with protests about benefit denials, protests against review and appeal determinations or the procedures themselves, perceived as unfair or in violation of law, have taken the form of increased resort to benefit program review and appeal procedures, class actions in court, and complaints to Congress.

3. Some benefit programs contain costs by placing the risk of payment for provision of services not covered by the program on the providers of these services. This may encourage increased provider responsibility regarding the provision of services to beneficiaries. But it sometimes results in denying beneficiaries legally allowable benefits and due process. Because there is generally no mechanism in benefit programs for verification of coverage, providers may inform beneficiaries that certain services will not be reimbursed by the benefit program. If beneficiaries want the service, they will have to pay for it themselves. In this way, providers avoid the risk of nonreimbursement for services performed. The beneficiary has no recourse to request payment from the benefit program because the determination of non-payment has been made informally and prematurely by the provider.

Implications for a New Long-Term Care Program— A new long-term care program will be required to implement a review and appeal mechanism that complies with constitutional and statutory standards of fairness. The program will face challenges similar to existing programs in terms of allocating funds for an effective process.

As with existing benefit programs, if beneficiaries or service providers perceive reviews as unfair, they are likely to protest by resorting to the courts, Congress, and the review process itself. Such actions may be costly to the program both monetarily and in terms of loss of credibility with beneficiaries and the public. If the long-term care program requires providers to assume the risk for coverage of non-reimbursed services to beneficiaries, it may create a dilemma for providers and beneficiaries similar to that in existing programs. Although there may be sound fiscal reasons for this policy, policymakers need to be aware that it could be perceived as unfair by providers and beneficiaries seeking fair claims determinations.

One approach to mitigating tension between providers and beneficiaries would be, whenever feasible, for a long-term care program to establish procedures for determining program coverage of specific services prior to providing them.

Policymakers need to understand the potential impact of risk placement decisions on long-term care beneficiaries who are dependent on providers for the basics of life over an extended time period. They should carefully consider what sort of risks on providers are likely to create inherent distrust of them among beneficiaries.

ASSUMPTION: Benefit programs have an obligation to insure that the critical components of due process function effectively.

Although the requirements of due process in review and appeal procedures are interpreted differently among the various benefit programs, there are certain basic components that the courts have identified as critical to fair determinations. While these procedures often function effectively, some policies or practices may either be unfair or create the perception of unfairness among beneficiaries or the general public.

Lesson: Representation by Lawyers or Lay Advocates

1. Although the nonadversarial nature of benefit program review and appeal procedures is generally acknowledged as appropriate, a right to representation at some stage in the process is considered an essential element of fairness. Benefit programs acknowledge that representation significantly increases the likelihood of their paying disputed claims.

Despite the availability of several sources of attorney compensation, a significant number of beneficiaries do not have, and cannot get, legal representation at appellate level hearings. In addition, very few beneficiaries have any type of representation during the early stages of the review process. This may be because beneficiaries are not adequately informed about its usefulness, it is unavailable, or programs do not encourage its use.

2. Many beneficiaries making claims against benefit programs are vulnerable and inarticulate. Because the pool of attorneys is limited, administrators and advocates have suggested using lay representatives in the review and appeal process. Adequate training and supervision of lay representatives, as well as assurances of their independence from benefit program control,

are considered prerequisites to their augmenting traditional legal representation of beneficiaries.

Implications for a New Long-Term Care Program— A long-term care program inevitably will increase the number of claims subject to review and appeal, and further tax the limited resources available for representation of beneficiaries. Many of the beneficiaries of a long-term care program are likely to be particularly vulnerable both physically and cognitively, so that this program may need to provide substantial resources for representation if its procedures are to be perceived as fair. Policymakers need to consider the extent to which the program will provide assistance for payment of either lay representatives or attorneys, the stage at which representation is to be authorized, and the form it will take. The establishment of a new program of lay representation might provide the impetus to explore effective alternatives to attorney representation for all benefit programs.

Lesson: Adequate Notice and Timely Review

1. Adequate notice, i.e. notice that clearly states the reasons for denial of a claim and beneficiaries' rights to review and appeal, has been extremely difficult for benefit programs to formulate. Timely review of claims, particularly important for low-income, frail or disabled individuals who rely on benefit payments for the basics of life, also has eluded benefit programs. Although there are reasonable explanations for these failures, including complexity of notice requirements and inadequate staff to handle the claims caseloads expeditiously, the adverse impact on beneficiaries often jeopardizes due process.

One reason for the lack of clarity of notices is the use of bureaucratic, legal or other technical language to communicate with beneficiaries, many of whom have only an eighth grade education. Another is that the use of computer-generated notices frequently produces stilted language. Inconsistency in the language or content of notices also has been identified as a problem. This has occurred in programs delegating review and appeal functions to several contractors without undertaking to establish uniform standards or rules of operation. Another problem, insufficiently specific reasons for denial of claims, has been identified by the courts and the General Accounting Office as violative of due process requirements.

2. The slowness of the review and appeal process in benefit programs can have dire consequences for beneficiaries. Slowness of adjudication has been criti-

cized by Congress, the courts and GAO. Frequently, attempts to speed up initial determination or reconsideration by actions such as instituting claims processing quotas have resulted in increased claims denials, many of which are reversed at later appellate stages.

Because of the time and effort involved in pursuing review and appeal rights, less assertive beneficiaries may be accepting denials of benefits to which they are entitled. While this outcome may result in savings to the benefit programs, it is inconsistent with achieving fair determinations of benefit eligibility.

Implications for a New Long-Term Care Program— A long-term care program will be faced with the same dilemmas regarding notice and timely review that plague existing programs. The due process problems can be reduced in this program if, from the beginning, the program assumes responsibility for developing and implementing a system of uniform notices. The clarity and appropriateness of notice language is likely to evolve over time, but bureaucratic sensitivity to notice-related issues could reduce litigation and complaints to Congress. The long-term care program can substantially lower the time involved in the review and appeal process by insuring, from the beginning, that adequate staff resources are devoted to these functions, and that personnel are trained to provide expeditious, fair reviews, based on a complete record.

Lesson: Access to Information Critical to Determinations

Due process requires that beneficiaries have access to information on which decisions are based. Furthermore, the Administrative Procedure Act requires that benefit programs publish final rules in the Federal Register prior to implementation, and provide the public an the opportunity to comment on the rules before publication. Benefit programs, however, communicate most of their policies and orders regarding review and appeal procedures through limited circulation manuals, directives to specific organizational units, or informal contacts. This restricts beneficiary access to information that forms the basis for denial determinations, making it difficult to argue effectively. Benefit programs may avoid statutory requirements because the time consumed and expense incurred makes compliance unrealistic. Their policies generally must respond to rapidly changing technological and economic circumstances. In addition, these programs are required to make a high volume of review and appeal determinations quickly.

But the experience of benefit programs indicates that, in avoiding these requirements, programs have become lax in their obligations to inform and involve the public and interested parties in articulating program policy. Following from this, programs have become insufficiently accountable to beneficiaries and providers for consistent and open decisionmaking on claims. As a result, benefit programs are perceived as developing policies and practices that foster denials. Courts, Congress, special commissions and the GAO have found some of these to be patent violations of due process.

Implications for a New Long-Term Care Program— A long-term care program has the opportunity to establish its own policies on informing the public and beneficiaries about policies or practices that affect payment of claims. An information policy that insures accessibility of relevant internal decisions and directives, either by encouraging publication or developing alternative mechanisms for information sharing, promotes fairness in the review and appeal process. As with existing programs, withholding information from those who might be adversely affected by it could result in litigation, protests to Congress, or the establishment of investigatory committees. A long-term care program needs to balance cost savings derived from systematically withholding information against the increased monetary and good-will costs of various types of protest.

Lesson: Determination Based on an Adequate Record

Adequacy of the record on which claims review and appeal determinations are made is related to information accessibility. In order to insure fair decisions, benefit programs need procedures for development of adequate information about beneficiaries' medical conditions, ability to function, or any other relevant matters. Adequate development of claims records is often complicated by difficulty in obtaining critical information or by the nature of a particular beneficiary's circumstances.

Benefit programs have been criticized for failure to implement policies or practices that encourage staff, particularly at the early stages of the review process, to develop accurate and complete claims information, including ordering medical examinations when appropriate. This failure may follow from a decentralized or poorly monitored review process, delegation of record development to private contractors without adequate supervision by the program, or allocation of inadequate resources to this function.

The results have been creation of delays in the review and appeal process and frustration of appellate level adjudicators attempting to rely on records developed at an earlier stage as the basis for fair decisions. The most serious consequence for due process is that federal programs systematically countenance claims denials based on inadequate or inaccurate information.

Implications for a New Long-Term Care Program—Compilation and evaluation of information may be particularly difficult in a long-term care program because of the progressive deterioration in the condition of many beneficiaries and the frequent reassessment of their needs. Another difficulty may arise if the most regular observers of a beneficiary's condition are family caregivers or others who are not formal participants in the claims determination process.

As in existing programs, a new program will be required by law to base benefit-related determinations on accurate and complete claims records. Unfortunately, there are few viable models for effective enforcement of this obligation. Even though the requirement to develop an adequate record is difficult to monitor, long-term care program planners might consider developing mechanisms for this in order to avoid the cost consequences of unnecessary delays in the review and appeal of claims.

Ways in which a long-term care program can improve its capacity to develop accurate and complete claims records include: provision of adequate, well-trained staff at each level of the process, motivated to make fair decisions; and participation of beneficiaries and their representatives in the information collection process.

In addition, a long-term care program might consider developing standards and guidelines for acquiring and evaluating critical information. It could monitor record development activities and hold program administrators accountable for meeting program standards.

Lesson: Verbal Statements in Front of Decisionmaker

1. Experience of benefit programs indicates that beneficiaries receiving face-to-face reviews of some sort by decisionmakers are significantly more likely to prevail than those who receive only on-the-record determinations. But most benefit programs discourage face-to-face reviews until a late stage of the review and appeal process.

Face-to-face reviews by decisionmakers, while more time consuming and expensive than on-the-record reviews, generally are considered to increase beneficiaries' perceptions of fairness in conduct of reviews or appeals. This may be so even if the reviews result in denial of benefits. To the extent that early opportunities for face-to-face reviews increase beneficiary satisfaction with the determination process, they could save benefit programs money and time spent on prolonged appeals. GAO and expert commissions have recommended that benefit programs institute more early face-to-face reviews by decisionmakers.

2. As the volume of hearings has increased, benefit programs, seeking to increase the efficiency and reduce the cost of the review and appeal process, have considered conducting hearings by telephone. Some programs continue to offer this alternative to beneficiaries. In general, experiments with telephone hearings in benefit programs have not been an unqualified success. Despite certain perceived advantages to frail populations in not having to travel to hearing sites, many knowledgeable individuals consider that telephone hearings increase the inherent imbalance of power between decisionmakers and beneficiaries.

Implications for a New Long-Term Care Program—Face-to-face review by a decisionmaker at some stage in the review and appeal process is established practice in benefit programs. It may be particularly critical in a long-term care program where initial claims decisions are made by case managers. In order to develop or monitor effective care plans, case managers are likely to encourage participation of the beneficiaries and their caretakers. Beneficiaries, accustomed to involvement with decisionmaking in the long-term care program, will expect to have direct access to decisionmakers reviewing their claims. Because needs reassessments may be frequent and changes in the services provided may be subtle, the ability of reviewers to evaluate beneficiaries' status first hand may be even more important to fair determinations than in existing benefit programs.

Although telephone hearings should be considered for those beneficiaries who want them, a long-term care program should not rely on them. Their drawback, particularly for elderly persons who may have hearing loss or are confused, or for mentally ill individuals, is evident.

Lesson: Hearings Prior to Denial or Termination of Benefit

The issue of whether benefit programs, providers or beneficiaries should pay the costs of care or of pension payments during the pendency of claims reviews or appeals has economic and administrative implications for all parties. Because frail, low-income beneficiaries, in particular, may rely on payments from benefit programs as their lifeline, due process concepts afford them some protection, although its extent is unclear. Particularly when termination of ongoing benefits or services, or denial of critically needed medical care are at stake, beneficiaries may be entitled to some sort of review or appeal procedure prior to withdrawal of benefits or refusal to pay for care. But the need for a speedy determination may take precedence over considerations of beneficiary vulnerability. In this situation, due process generally requires that the beneficiary have access to a benefit program's established review and appeal process immediately after an adverse determination has been made.

Implications for a New Long-Term Care Program—The law regarding who bears the cost of care pending exhaustion of beneficiary review and appeal rights is in flux. Consequently, it is difficult to predict the legality of specific policies that a long-term care program might develop to address this issue. In developing review and appeal procedures for a long-term care program policymakers need to determine the circumstances in which benefits will be available pending a decision to terminate benefits. Beneficiaries of this program will be physically or mentally vulnerable and may also be poor. The home-and-community-based service aspect of the program, by its nature, is focused on assisting individuals with substantial dependency to function outside of an institution. Premature deprivation of support could be devastating.

Also, the definition of termination in a long-term care program is more complex than for most existing benefit programs. Once an individual receives benefits based on eligibility for assistance with ADLs, changes in the care plan are a more likely occurrence than total termination. Policymakers need to consider carefully which of these changes could not be implemented prior to the beneficiary's exercise of some type of review and appeal rights.

Lesson: Decisions by an Impartial Individual or Panel

When the review and appeal process is linked closely to program administration, policies insuring the independence and integrity of program reviews and appeals are essential. Benefit programs have developed a variety of mechanisms intended to separate these procedures as much as possible from ongoing program influences. In addition, benefit programs generally provide for some sort of judicial review. Beneficiaries' representatives, Congress and the courts have expressed concern about the ability of decisionmakers to function independently, and about deliberate program intrusions into this sphere of activity. Three significant considerations in developing independent mechanisms are:

(1) Insuring the ability of high level, expert administrative adjudicators such as administrative law judges to make independent, objective decisions about benefit eligibility;

(2) Understanding that when a benefit program designates private contractor organizations as claims adjudicators and reviewers, contracts with these organizations must establish sufficient independence from the benefit program to insure fair decisionmaking; and

(3) Avoiding a review and appeal structure contained entirely within the agency responsible for the benefit program, with no recourse for beneficiaries to the judicial system.

Implications for a New Long-Term Care Program—The initial assessment of eligibility for a long-term care program and the development of beneficiaries' care plans are likely to be performed by organizations or individuals employed by, or contracting with, the long-term care program. These decisionmakers may be expected to interpret policies and directives relating to claims determinations from the perspective of the program, or to follow program cost containment guidelines. Because of this inherent potential for conflict of interest between beneficiaries and initial decisionmakers, due process requires that policymakers be particularly sensitive to establishing mechanisms that will insure impartial reviews and appeals.

WHAT MECHANISMS MIGHT BE DEVELOPED TO PROVIDE ADVOCACY SERVICES ON BEHALF OF BENEFICIARIES IN THE BENEFIT PROGRAM REVIEW AND APPEAL PROCESS, OR TO INCREASE THE ABILITY OF BENEFICIARIES TO ADVOCATE FOR THEMSELVES?

One crucial element of due process, beneficiary representation, is most appropriately provided by organizations or funding sources outside the authority of the benefit program. Effective representation and education of beneficiaries about their rights can serve as checks on failure to provide for the other legally mandated elements of administrative due process.

The caseloads of existing benefit programs are not being served adequately by attorneys or lay advocates. A major reason for this is that most beneficiaries cannot afford to pay private attorneys the actual cost of their services. The community of attorneys willing to undertake *pro bono* representation of beneficiaries cannot begin to meet the need for their services. The pool of committed and trained volunteer lay representatives assisting in certain programs and geographic areas cannot fill the gap either. Today, few programs rely on paid and trained lay individuals to represent benefit program beneficiaries. With the enactment of a long-term care benefit program the already overwhelming population of unrepresented beneficiaries will increase significantly. What policies and programs should Congress and national organizations concerned about beneficiary representation pursue in order to institutionalize effective benefit program advocacy services on a national basis?

Funding Sources for Existing Advocacy Programs

The federal government provides several sources of funding for advocacy on behalf of low-income individuals regarding benefit claims. Some programs receive funding from more than one of these sources.

The Legal Services Corporation Act authorizes funds for offices that provide legal services to low income individuals at the local level. These offices may represent elderly or disabled clients in their claims against benefit programs.¹⁵⁷

¹⁵⁷ 42 U.S.C., Sec. 2996, *et seq.*

The Older Americans Act requires that funds granted to the states and distributed to Area Agencies on Aging be used to provide legal assistance to the elderly.¹⁵⁸ This is defined as "legal advice and representation by an attorney (including, to the extent feasible, counseling or other appropriate assistance by a paralegal or law student under the supervision of an attorney), and includes counseling or representation by a nonlawyer where permitted by law, to older individuals with economic or social needs."¹⁵⁹ This statute also requires states to fund an extensive network of ombudsmen to represent nursing home residents in disputes with nursing homes, and authorizes states to extend this service to residents of board and care homes or recipients of home health care.¹⁶⁰ In addition, this Act provides limited resources to states to demonstrate and evaluate the effectiveness of consumer protection projects intended to protect older individuals receiving services in the home that are furnished or assisted with public funds. State or local ombudsmen and legal assistance agencies may be supported under this program.¹⁶¹

The Equal Access to Justice Act¹⁶² authorizes compensation for attorneys successfully representing clients in cases against federal agencies in federal court. Certain actions against benefit programs are included. Individual practitioners and legal services attorneys may apply for compensation under this act. The Developmental Disabilities Assistance and Bill of Rights Act¹⁶³ provides payment to state-designated agencies to provide protective services for developmentally disabled children and adults, and to represent them before administrative agencies or courts.

The Protection and Advocacy for Mentally Ill Individuals Act,¹⁶⁴ provides payment for services similar to those for the developmentally disabled, only to agencies already receiving funds under that legislation. In addition to federal funding, advocacy and consumer education programs may receive financing from various state sources (e.g. agencies focused on aging or disabled populations, health departments or attorneys general offices), and from private organizations such as the American Association of Retired Persons or the National Council of Senior Citizens. Direct compensation by clients, with or without a benefit program's agreement to withhold payment from benefits owed, offers another source of private payment for client representation.

¹⁵⁸ 42 U.S.C. Sec. 3007(a)(15).

¹⁵⁹ 42 U.S.C., Sec. 3022.

¹⁶⁰ 42 U.S.C., Sec. 3007(12).

¹⁶¹ 42 U.S.C., Sec. 4028.

¹⁶² 28 U.S.C., Sec. 2417 (b), (d).

¹⁶³ 42 U.S.C., Sec. 6001, *et seq.*

¹⁶⁴ P.L. 99-319.

Existing Advocacy Programs

A variety of advocacy programs, some using attorneys, others lay individuals or a combination of legal and lay staff, actively provide some type of advocacy to beneficiaries. These programs may receive federal and/or state or private funding. Some rely heavily on volunteers, others on paid staff. Categories of services these programs provide include:

- legal services (general or specializing in a type of claim)
- hot lines
- ombudsman
- developmentally and mentally disabled protective services
- benefit counseling services
- *pro bono* legal representation
- professional lay representation
- consumer education

Some programs combine several categories of service. Without evaluating either the programs or the services that they provide, it is useful to include examples of existing programs with some experience in advocating for or providing consumer education to the beneficiary community.

Legal Services—Legal services organizations provide legal advice and representation for low income clients either on a sliding fee scale basis or for free. They also may mount class action suits which can be effective in attacking the policies and practices of benefit programs.

Typically, clients walk into or telephone a legal services program to ask for assistance without having had prior contact. Ethnically based organizations, unions and others may also sponsor legal services programs for their members. In addition, some legal services programs concentrate on a particular category of client. The National Senior Citizens Law Center, for example, represents the elderly in a variety of matters involving benefit programs. National Veterans Legal Services provides similar assistance to veterans.

In recent years, a number legal services programs have been established to represent Medicare beneficiaries seeking payment of claims under the various Medicare programs. One program in Connecticut, Legal Assistance to Medicare Patients (LAMP) claims a 95 percent success rate, for 700 clients served, in obtaining benefit awards for clients.¹⁶⁵

¹⁶⁵ Legal Assistance to Medicare Patients, Willimantic, Ct., "Your Right to Medicare Benefits for Home Health Care, May 1989." (pamphlet)

Similar programs, for example, Massachusetts Medicare Advocacy Project and Medicare Advocacy Project of Los Angeles, assist beneficiaries with a range of concerns in relation to Medicare.

Hot Lines—Legal hot lines are being established for beneficiaries to call in order to receive information and advice about claims-related problems. Their structure and bureaucratic relationships may be critical to successful operation. The Legal Council for the Elderly (LCE), an affiliate of the American Association of Retired Persons, established a Hotline pilot project in Pittsburgh, PA in 1985 that provides free legal advice by telephone to all older residents of the area. There are now four LCE Hotlines in the United States. Attorneys receiving hotline calls may provide only brief services, but may make referrals to social or legal services programs or private attorneys.¹⁶⁶

Ombudsman—The ombudsman, as developed under the Older Americans Act, is a trained volunteer, supervised by an attorney, who advocates on behalf of nursing home residents regarding quality assurance issues. Residents may complain, for example, that the nursing home is providing inadequate service or abusing and harassing the residents.

Although recent legislation authorizes extension of this activity to board and care homes or home care, most states have not done so. In part, this is because there has been no increase in funds accompanying this authorization. Also, the protection of clients from poor quality service in the community setting requires a different model of practice than nursing home advocacy. The ombudsman would have to be trained differently in order to handle a large volume of small concerns that require immediate attention.

The extension of the ombudsman concept to more generalized advocacy on behalf of beneficiaries of a long-term care benefit program would, according to some, stretch the resources of ombudsman programs substantially, and require staff to deliver services different in critical ways from those contemplated by the Older Americans Act. Existing ombudsman programs deal with local level service providers, using volunteers to perform specific tasks. Representation of beneficiaries, or even assistance with filing claims and requests for review, would require a completely different orientation, intensive training and intensive supervision.¹⁶⁷

¹⁶⁶ *Elder Law Forum*, Legal Counsel for the Elderly, 1, (5) (September/October 1989).

¹⁶⁷ Ann Lordeman, National Association of State Units on Aging, conversation with author (Washington, D.C.: November 15, 1989).

Another issue in expanding the ombudsman program to serve long-term care beneficiaries is lines of authority. Currently, the ombudsman program is either located within an Area Agency on Aging or is a contractor to the agency. These agencies may become responsible for administration and case management in a long-term care program. An effective long-term care ombudsman program would have to function independently of the organization—most likely a public agency or its contractor—that develops and manages the care plans for beneficiaries.

Developmentally and Mentally Disabled Protective Services—Under federal law, states are required to establish units that provide protective services for the developmentally and mentally disabled, and to provide advocacy on their behalf, including asserting their entitlements to various federal benefits. The Maryland Developmentally Disabled Center is an example.

This center operates an advocacy and protective services program at three locations in the state. It uses trained lay advocates supervised by attorneys to handle 3,000 cases a year on a range of issues. Because the center is responsible for the developmentally disabled, it receives funds to provide similar services for the institutionalized mentally ill. The staff handles its own caseload including interviewing clients, filling out applications and other forms for SSI, and representing beneficiaries through the ALJ level in SSI cases. Center attorneys represent beneficiaries in court and implement proactive strategies to gain enforcement of rights. The Center provides technical assistance and training to its satellite offices.

Benefit Counseling Services—Particularly in the area of medical benefits, programs, staffed largely by volunteers, provide extensive counseling and related services to beneficiaries. The predominant program is the American Association of Retired Persons' (AARP) Medicare and Medicaid Assistance Program (MMAP), established 10 years ago, and currently serving 60,000 clients in 35 states. About 3,400 lay volunteers counsel beneficiaries as to their options and entitlements, and assist in understanding benefit program procedures, filling out forms, and finding experienced advocates. A unique feature of the program is that volunteers are available to meet with clients in their homes. AARP's participation in MMAP includes establishing contact with local nonprofit agencies with which MMAP can affiliate. Through these agencies with broad links to the community, clients are referred to MMAP.

In addition, AARP provides technical assistance, develops and distributes manuals and other material,

provides regular training of new volunteers, updates experienced volunteers on new benefit program developments, coordinates among MMAP programs and supervises the entire project.

Similar programs are being funded by state governments in Massachusetts, New Jersey, North Carolina, Illinois, Washington, California and Maryland. Maryland's Senior Health Insurance Counseling and Assistance Program (SHICAP) focuses on Medicare and Medigap insurance. Staff provides claims assistance, and files requests for review and reconsideration on behalf of beneficiaries. Legal backup is available for its claims assistance work. In addition, the Maryland Attorney General, through its Consumer Health Advocate Office, litigates claims and related cases.

Pro Bono Representation—Although private attorney representation of indigent clients is established practice, it only scratches the surface of the need for legal assistance. Several states have programs encouraging attorneys to provide *pro bono* services to the elderly. Similar programs may be available for the handicapped, mentally ill or developmentally disabled. Legal Counsel for the Elderly (LCE) provides training for attorneys interested in representing benefit program beneficiaries without receiving compensation. The American Bar Association, through its Commission on the Legal Problems of the Elderly and the Private Bar Involvement Project, publishes literature and holds conferences to facilitate the participation of the private bar in developing special projects, called *Pro Bono Seniorum*, to represent the elderly.

One private program, The Volunteer Lawyers Project, established by LCE in 1977, trains members of the bar, frequently affiliated with law firms, in all areas of elderlaw. LCE then assigns cases to these attorneys, providing them with technical assistance and maintaining quality control. The attorneys accept no fees for their services. In addition, LCE provides legal representation directly to low-income elderly clients.

Lay Representation—A long-term care program will drastically increase the number of benefit program beneficiaries in need of counseling, claims assistance, and representation. A partial response to this need is the establishment of a new profession of lay benefit specialist. Currently benefit program regulations and, in some states, the law inhibit the development of a corps of lay advocates to perform certain functions traditionally within the province of the legal profession.

Barriers to Developing a Substantial Corps of Lay Advocates—In order to facilitate representation by nonlawyers before benefit programs, these programs must issue clear regulations implementing the authority granted them by the Administrative Procedure Act to permit lay representation. Unless the benefit programs clarify their status, nonlawyers attempting to provide assistance to beneficiaries may fear prosecution under state laws for unauthorized practice of law. In addition, some state laws need to be amended in order to grant lay advocates the right to provide assistance, including some level of representation, without fear of reprisals from the state bar.¹⁶⁸

A Benefit Specialist Program—The Center for Public Representation in Madison, Wisconsin has developed a statewide network of lay benefit specialists. The program was established in 1977 on the premise that low income elderly were not receiving their fair share of government entitlements because the benefit programs were too complex and the bureaucracy faceless. In order to maximize the resources available for advocacy, the Center developed mechanisms for training lay personnel to be advocates, continually updating them on benefit program developments, and providing ongoing attorney supervision. At the point when a case requires an attorney's skill, it is transferred to legal staff.

Wisconsin has placed a benefit specialist in the office of every County Committee on Aging. The Center provides back-up for county offices, direct representation and technical assistance.

¹⁶⁸ Zona Fairbanks Hostetler, "Nonlawyer Assistance to Individuals in Federal Mass Justice Agencies: The Need for Improved Guidelines," *The Administrative Law Journal*, 2, (1) (1988): 114, *et seq.*

Consumer Education—The publication of handbooks, guidelines and pamphlets describing beneficiary entitlements and rights to review and appeal from benefit denials is widespread. Benefit programs are required to publish this sort of literature. Insurance carriers and fiscal intermediaries, providers, consumer organizations and others may also provide it. The American Association of Retired Persons publishes a large volume of information intended to inform older consumers about subjects of interest to them, including benefit entitlements. National organizations representing handicapped or developmentally or mentally disabled individuals probably provide this service to their members also. The quality of publications from so many sources is bound to vary, and the effectiveness of their distribution has not been systematically evaluated.

Consumer education efforts tend to be focused on particular topics. The development of materials, even within one organization or agency, often is not adequately coordinated, so that there may be a lot of information available about some aspects of benefit programs and not enough about others.

Summary

Advocacy and consumer information will be critical to assuring that a long-term care program's claims review and appeal procedures comply with due process and are available to all beneficiaries with a legitimate need to use them. Fortunately, there are a number of innovative programs that might serve as models for encouraging beneficiaries of this program to be effective consumers of its services, and, when necessary, to assert their rights to the services that it provides.

Staff Memoranda and Briefing Papers

Canada's Health Care System: Questions Americans Should Ask *

It is not hard to understand why the Canadian health care system looks attractive to Americans concerned about both large numbers of uninsured citizens and high medical costs. The most easily measured attributes of the Canadian system look very appealing:

- universal coverage, with no financial barriers to care (compared to 31–37 million uninsured in the U.S.)
- per capita spending at two-thirds the U.S. level (about \$1,200 in adjusted U.S. dollars in 1985, compared to about \$1,800 in the U.S.)
- slower rates of increase in per capita health care costs, measured in constant dollars (3.1 percent per year in Canada, 4.8 percent per year in the U.S., 1971–1985).

To draw lessons from the Canadian experience, however, it is necessary to look at what is less easily measurable in the system—in particular, the factors that explain lower spending, the consequences of lower spending, and the ways in which spending is held in check.

Why Does Canada Spend Less?

Canada's lower health spending per person is not a function of fewer doctors (physicians per person are about equal in Canada and the U.S.), fewer hospital beds (Canada has more than the U.S.), or lower use of institutional care (Canadians use more hospital days per person than Americans).

Rather, lower spending reflects lower costs per hospital day, lower fees to physicians, and lower administrative costs. Lower costs per hospital day appear to mean lower "intensity" or resources per day of hospital care—partly a reflection of lower use of sophisticated technologies, fewer staff, and greater use of hospitals by chronic care, rather than acutely ill, patients. Lower physician fees reflect the fact that in Canada, in contrast to the U.S., government determines fees and can, in fact, keep fee increases below rates of inflation. Administrative cost savings come

from universal eligibility, common benefits, and reliance on a single (government) insurer—eliminating marketing expenses, eligibility and benefit determinations, and simplifying revenue collection and payment of bills.

What are the Consequences of Canada's Lower Spending?

In terms of services provided, the most visible consequence of lower spending in Canada appears to be lower availability and use of sophisticated technologies. Hospitals are paid global budgets and must decide how to allocate those budgets among alternative activities. In addition, they must receive government approval to adopt new technologies. The result is that specialty services like cardiac surgery or radiation therapy are available in fewer Canadian than American hospitals. Furthermore, high occupancy rates, partly related to long stays by chronic care patients, may tie up hospital beds and create service delays (e.g., for cardiac or hip replacement surgery).

What we'd most like to know about lower spending is what it means for people's health. Unfortunately, our capacity to provide that answer is decidedly limited. We measure health status at very gross levels—primarily in terms of death rates, at various ages, and death rates are affected by numerous other factors besides health care. Canada's lower spending is not associated with lower performance on these measures; in fact, Canada has substantially lower infant mortality rates than the U.S.

Such gross measures, however, do not tell us whether lower availability and use of technologies or delays in surgical procedures, which may occur in the Canadian system, have negative consequences for health.

How is Spending Held in Check?

Because there is only one payer for health care in Canada—the government in each province—and be-

* Briefing paper prepared by Judith Feder for July 27, 1989, working meeting.

cause the government sets rates, government decisions determine what providers get paid. By limiting what it will pay, the Canadian system limits the supply of health care services. For hospitals, limits come from global budgets and approval of capital expenditures. For physicians, government limits access to technology (provided primarily in hospital settings) and limits fees. In Quebec, limits apply to total expenditures (per capita incomes, for general practitioners). Attempts to incorporate similar caps in other provinces have aroused considerable controversy.

Physicians fees (and expenditure targets in Quebec) are set through negotiation between provider associations and provincial governments. The process is one of political conflict, "played out," as Canadian economist Robert Evans describes, "as large-scale political theater, with all the rhetorical threats and flourishes that political clashes require." Conflicts over government's right to prohibit physicians from billing patients led physicians to strike in Ontario, and physicians have used the courts to challenge provincial restrictions on physician location.

Although costs increase more slowly in Canada than in the U.S., Canadians themselves have not been satisfied with the growth in their expenditure levels. Health expenditure increases have stayed more in line with general inflation rates than in the United States, but Canada's care costs have increased at significant annual rates.

Efforts to tighten cost control have taken various forms. In 1977, the federal-provincial financing formula was changed. Instead of splitting costs 50-50, whatever their level, the new law fixed the annual rate of increase to parallel the rate of growth in the GNP. As a result, the provincial share of costs has increased—in Quebec, reportedly, to 61 percent.

At the provincial level, efforts to achieve greater cost control have focused on utilization of physician

services. Constraints on fees were accompanied in Canada by an increase in the volume of services physicians provided, thereby undermining government's capacity to control costs. Outside Quebec, that pattern has persisted over time.

Quebec responded by refining its fee schedule and by capping GP incomes and total expenditures on specialists' services: if expenditure increases exceed predetermined levels, subsequent fee increases are reduced.

Although other provinces may ultimately follow Quebec's lead, they have been less aggressive in controlling total expenditures and less successful in containing costs. Some Canadian provinces have begun to look beyond fee limits to controls on physician supply as a means to limit spending.

Even proponents of the Canadian system do not argue that cost containment is easy or without conflict. Rather, they argue that conflict can be managed and that policy refinement and political will can keep spending in bounds.

What are the Lessons From the Canadian Experience?

- Universal coverage (indeed, care that is free to consumers) can be compatible with lower rates of spending increase than the U.S. now incurs.
- Slower expenditure growth depends on policy tools and political willingness to limit amounts paid to providers.
- Slower spending growth does not guarantee greater efficiency or necessarily threaten quality or access. Consequences should be measured, not assumed.

Financing Long-Term Care in Canada *

Introduction

Despite similarities between Canada and the United States in their geography, demographics and cultural heritage, Canada has chosen a different approach to conceptualizing the role of government in financing and delivering long-term care. However, it is important to state upfront that there is **no one Canadian long-term care system**. Each of the 10 provinces is responsible for administering its own long-term care programs. There is, therefore, wide variation in the availability of and access to services, particularly home and community-based care. Given this important caveat, the Canadian long-term care experience may provide some guidance for reform of long-term care policy in the United States.

Federal Support for Long-Term Care

The financing of long-term care is best understood within the context of Canada's universal health insurance system which has been in place for hospitals since 1958 and for medical care since 1968. As a response to provincial complaints that the health insurance program created incentives for high-cost hospital-based care, the 1977 Established Programs Financing Act provided to each province a per capita extended care block grant. The amount (set at 20 Can \$ per capita in 1977, and at 49.15 Can \$ in 1988-99) has an automatic escalator for inflation. The purpose of the grant was to permit provinces the flexibility to introduce less expensive and perhaps more desirable forms of care than hospital care, such as nursing home care, community-based care, and home care. In contrast to the health insurance program, no stipulations for comprehensiveness and universality were attached to the extended care grants.

The Canadian federal government provides additional subsidies (matched 50-50 with the provinces) for care to the poor.

* Briefing paper prepared by Robyn I. Stone for July 27, 1989, working meeting.

Institutional Care

With the assistance of the annual federal block grant, all but three of the Eastern-seaboard maritime provinces provide universal entitlement to nursing home care. Eligibility is based on functional disability. No income or assets tests are applied, although the consumers do pay part of the bill. All nursing home residents are charged a monthly co-payment for room and board which equals the maximum federal monthly income security benefit less a comfort allowance (about \$90 per month in 1984). This copayment is indexed to rise with the cost of living and publicly financed pensions.

The three provinces without universal nursing home coverage contribute to the financing of nursing home care through a residual program for people who have "spent down" to poverty (similar to Medicaid reimbursement for institutional care in the United States).

Home and Community-Based Care

There is much variation among the provinces in the provision of home and community-based care. Manitoba, which has a province-wide, universal, no-cost-to-consumer home and community-based care program, has the oldest and most fully-developed system in Canada. This program, administered by the Office of Continuing Care, has a single point of entry for both institutional and community-based and home care. A standardized assessment tool is used to determine eligibility. Both level of functional disability (regardless of age) and availability of informal supports are considered in determining the services government will provide. Although the need for institutional care is recognized, the goal of the Manitoba long-term care program is to keep disabled persons in the community as long as possible by providing a range of personal care and other nonmedical services.

British Columbia's long-term care program is patterned after the Manitoba model. The program serves

all adult residents, although children do receive home nursing care. Homemaker services and handyman services (the primary home care services offered by British Columbia's Long-Term Care Program) are not free; a sliding scale based on income is used. Nevertheless, no one is impoverished in order to be eligible for services. Case managers are responsible for assessing and authorizing levels of care in facilities as well as in the community.

In contrast, much of the publicly financed home care in Ontario, the most populous province, is medically oriented (analogous to the home health benefit under Medicare in the United States). Chronic home care services (e.g., personal care, homemaker chore) are available through the Ministry of Community and Social Services, but they are means-tested and targeted to the poor. There is no consistent case management.

At the opposite end of the spectrum are the relatively poor maritime provinces. They are piecing together home care programs based on existing resources, with Nova Scotia in the lead by developing a coordinated single-entry system through its homemaker agencies. Nova Scotia and New Brunswick are, in fact, attempting to develop their home care programs before instituting universal nursing home coverage. Therefore, it will be interesting to see whether subsidized home care will make nursing home care (which requires "spend-down") less attractive to disabled persons and their families.

Strengths and Weaknesses of Canada's Program

- **Strengths**—All Canadians, with the exception of residents of three maritime provinces, are entitled

to nursing home care. Although there is a standard co-payment for room and board, no one is pauperized in order to have access to institutional long-term care.

- In some provinces, publicly financed, non-medically-oriented home and community-based care is available free of charge (e.g., Manitoba) or on a sliding scale basis (e.g., British Columbia). These programs tend to have a single point of entry and a case management system which determines eligibility and service packages based on functional need and the availability of informal care supports.
- There appears to be no runaway utilization of home and community-based care programs in provinces that fund these services because of case management and the commitment to operate within available funds.
- **Weaknesses**—Home and community-based long-term care services are not available in all provinces. Even among provinces that finance care, there are differences in the types and amount of services provided. Access to community-based and home care, therefore, is inequitable across provinces.
- Many provinces attempt to control nursing home costs by limiting bed supply. Expenditure control that relies on constraining bed supply does not, however, guarantee efficient use of services. Use of hospitals for long-term care patients is suggestive of this inefficiency.
- Just as in the United States, Canada does not effectively coordinate health care services with nonmedical long-term care services. Furthermore, even though several provinces have developed home and community-based care programs, because Canada's health insurance program covers medically-oriented care in institutions or at home, these services receive greater emphasis.

Comparing Health Care Financing Across Nations: A Summary *

Coverage

- Outside of the United States, government assurance of universal health care coverage is the norm in industrialized nations.
- Universal coverage does not imply a centralized, government-run system. Rather it is achieved through a variety of mechanisms, ranging from totally publicly financed and owned systems (as in the United Kingdom) to systems with multiple insurance funds (as in Germany and France).

Financing

- Public spending as a share of total health spending averaged close to 80 percent for industrialized nations in 1986; in the United States, the proportion was 41 percent.
- Most countries employ a variety of public financing sources with some relying more heavily on general taxes, others on payroll taxes, and some on employee and/or employer premiums.
- All nations experienced substantial growth in health spending as a share of total output between 1960 and 1975, increasing, on average, from 4.0 percent of GNP to 6.0 percent.
- Between 1975 and 1985, growth in health spending as a share of output slowed substantially (6.9 percent of GNP to 7.3 percent, on average).
- Compared to other countries, the U.S.:
 - devotes the largest share of production output to health (11.1 percent in the U.S.; 7.2 percent on average for OECD nations, 1986)
 - derives the smallest share of spending from public sources (41 percent in the U.S.; 77 percent for all OECD nations, in 1986)

—spends the most on health care, per person (\$1,926 in the U.S.; \$958, on average, for all OECD nations, in 1986).

Controlling Costs

- Like the U.S., most industrialized nations today have come to question the resources they are devoting to health care and want to spend less.

- Unlike the U.S., most industrialized nations—even those with several insurance funds—had developed (by the 1980's) government authority over payment rates (and, in some cases, total expenditures) to providers.

- Willingness to use government authority to restrict expenditure growth, and the political conflict control entails, varies from place to place and over time. When willing, however, governments seem able to restrict cost growth.

- Annual increases in health prices above general prices are much greater in the U.S. than in other countries (3.4 percent in the U.S. versus 0.8 percent on average for seven major OECD nations, 1980–1986).

- By contrast, U.S. annual increases in use/intensity of service per person are relatively low (2.0 percent in the U.S. versus 2.5 percent on average for seven major OECD nations, 1980–1986).

Quality and Efficiency

- Lower expenditures on health care may mean less or different health care—particularly, in terms of ready access to high technology services. Lower expenditures also mean lower payments (and incomes) to providers of care.

- Expenditure controls have been instituted primarily to limit public expenses. Their consequences for

* Paper prepared by Judith Feder for July 27, 1989, working meeting.

quality, access, and efficiency have not been systematically evaluated.

- Higher expenditures on health care do not guarantee better health outcomes. While the U.S. ranks

highest among industrialized nations in spending, it ranks near the bottom with respect to infant mortality rates and only ranks in the middle with respect to life expectancy.

Comparing Financing and Delivery of Long-Term Care Across Nations: A Summary *

Comparing financing and delivery of long-term care across nations is complicated by differences in the way care is defined—e.g., what is an institution? What is medical vs. social service? It is further complicated by the lack of comprehensive, accurate data, particularly for care provided in people's homes or in the community. Keeping these limitations in mind, the following observations can be made about long-term care in industrialized nations:

Financing Long-Term Care

- In long-term care, unlike acute health care, universal entitlement without regard to income is not the norm among industrialized nations. In about half the OECD countries, government funding for institutional care is provided on a welfare basis rather than on an insured entitlement basis. Government-funded home care is even more likely to be targeted to the low-income population. Where entitlements exist, the benefits are limited. Some examples of these programs are:

- All Canadian provinces have an entitlement program for nursing home care; residents are required to pay the room and board portion of the costs but are not required to "spend down" their income or assets.
- In France, the medical and nursing costs in long-term care institutions are publicly financed, but room and board are the responsibility of the service recipient. Those who cannot afford the room and board costs must apply for welfare assistance and "spend down."
- The Netherlands covers long-term care under a national health insurance scheme, but care is limited to medically intensive services in nursing homes or in the community. Residents must pay for their own care in less medically intensive homes for the aged; for those who cannot pay part or all of the costs, the government makes up the difference through general revenues.

- In the United Kingdom, the National Health Service covers only medically-oriented long-term care. Provision of the bulk of long-term care is the responsibility of local social service agencies.
- Israel has recently implemented a long-term care insurance program which provides home care benefits (e.g., personal care, homemaker chore, adult day care) to the elderly disabled. The emphasis is on in-kind services. However, where services are unavailable and the eligible person is being cared for by a relative living with the beneficiary, cash benefits are provided on a temporary basis.

- Some industrialized countries in Western Europe (e.g., United Kingdom, Scandinavian countries, Australia) provide cash grants or constant attendance allowances to disabled elderly persons.

- At least three European countries (United Kingdom, Sweden, and Germany) pay relatives to provide care to disabled persons.

Management and Delivery of Services

- The type of services provided varies across countries. European countries historically developed more nonmedical institutions (like old age homes) than the U.S., Canada, and New Zealand. Within Europe, the Scandinavian countries, the Netherlands, and the United Kingdom offer a wider spectrum of service—home and community-based as well as institutional care—than other nations.

- The provision of home care as well as institutional care does not appear to reduce the use of institutions. Rather, generous public financing for home care is associated with higher use of institutional care, suggesting a greater willingness to spend on long-term care across the board.

- In most European nations, home and community-based services are administered locally. One innovation to improve coordination is the neighborhood or catchment area service center. This center functions

* Briefing paper prepared by Robyn I. Stone for July 27, 1989, working meeting.

as a focal point for arranging and delivering services to disabled persons in the community.

- Some nations (Denmark, Sweden, the Netherlands and the United Kingdom) have formal mechanisms to control admissions to institutions. Many also are exploring case management as a mechanism for controlling costs and ensuring the appropriate mix of home and community-based services.

- A shortage of nursing home capacity is a major difficulty in several European countries. Inadequate

nursing care in nonmedical institutions is also a growing problem.

- Several countries (e.g., United Kingdom, Denmark) make greater use of acute and psychiatric hospitals for long-term care of the elderly than does the U.S.

- Lack of coordination between medical and personal and support services is a problem facing all industrialized nations in providing long-term care.

Canadians' Use of the American Health Care System *

At our last Commission breakfast, you expressed an interest in learning if U.S. hospitals serve as a "safety-valve" for Canadians who have to wait for or can not get certain services. In order to assess the problem, the staff questioned knowledgeable individuals associated with a number of major medical institutions in the northern United States.

It was difficult to obtain precise numbers and to know how to interpret the numbers we got. Tourists with emergencies were indistinguishable from those patients who were referred to the United States. It was not possible to systemically identify referral patterns or types of treatment sought. We supplemented our data by asking American health officials for perceptions of Canadian usage of their institutions. Some of the respondents' comments are quoted below.

A better study would follow Canadian patients to examine usage patterns and their reasons for choosing American treatment over Canadian care, but it was beyond our capacity to do so in this short time period.

Summary of Findings

Of ten institutions surveyed, two gave evidence that they served a significant number of Canadians for certain specific procedures. The remaining American hospitals contacted treated a few Canadian patients for a variety of services and specialty care. These responses suggest that small numbers of Canadians may be using American hospitals for special services like coronary care and lithotripsy. These patients usually pay out-of-pocket for these services. However, there is no evidence that substantial numbers of Canadians are seeking care at American medical centers.

Institutions Serving Significant Numbers of Canadians—

- *Buffalo General Hospital, Buffalo, NY*—Overall, approximately three percent of Buffalo General's patients are Canadian. However, fifty of the hundred patients each month who receive lithotripsy to de-

stroy kidney stones are Canadians. This high use results from a formal arrangement with the province of Ontario.

Since there is a wait for Ontario's one lithotripter, the province will reimburse Buffalo General approximately \$3,000 for a single-stone procedure (hospital's charge is the \$4,000). This \$3,000 level of reimbursement is comparable to that which the hospital receives from insurers like Blue Cross, who use a DRG-based fee schedule, and is higher than NY State's compensation on behalf of Medicaid patients. The Ontario Ministry of Health has plans to purchase two more lithotripters, but has not yet done so. Officials stated that the acquisition process is slow and that they have decided to wait for the next generation of instruments.

- *University of Washington Medical Center, Seattle, WA*—Among the 72,000 non-emergency patients seen over the last five years, 59 have been Canadians. The dominant services for these patients are cancer treatment, neurosurgery for brain injuries and rehabilitation services. "Based on volume alone, this doesn't seem to be a large problem." However, 125 of the 250 *in vitro* fertilizations performed each year are done for Canadians. Patients pay out-of-pocket for this \$5,000 procedure.

Institutions With Very Little Use by Canadians—

- *Cleveland Clinic, Cleveland, OH*—The clinic serves 125,000 inpatients per year. In 1988, 143 Canadians made 402 non-emergency visits to the clinic. Although this number is low, it is higher than the 105 Canadians who sought treatment in 1986 and the 127 who came in 1987. The patients came for a variety of services, including cardiovascular, orthopedic, gastrointestinal and neurosensory treatment. "Some wealthy Canadians who get tired of waiting may seek treatment in the United States."
- *Mayo Clinic, Rochester, MN*—Canadian usage of the Clinic amounted to \$7,775,000 (\$5,375,000 for outpatient and professional services and \$2,400,000 for hospital services), which is approximately one percent of gross income. This utilization involved all services, across-the-board. Canadians tended to be well-off, as they paid out-of-pocket. "Thirty years ago, 20 percent of income came from Canadians, as opposed to only one percent now. This decline is

* Memorandum to Congressman Bill Gradison from Judith Feder and Pushkal Garg, August 18, 1989.

probably due to the change of payment plans in Canada. Canadian usage of our services is not that big a problem."

- *Massachusetts General Hospital, Boston, MA*—The admissions staff estimates that less than twenty patients per year are Canadian citizens. "It is our impression that the number is not significant."
- *University of Rochester Medical Center, Rochester, NY*—None of the more than 28,000 discharges in 1988 were from Canada. "This may change with the addition of liver and bone marrow transplant services to the hospital."
- *Detroit Medical Center, Detroit, MI*—"We see a small number of Canadian patients. They usually pay out-of-pocket and are seeking some sort of surgical procedure. Nevertheless, they are not coming over in waves."
- *Henry Ford Hospital, Detroit, MI*—Of 31,000 discharges per year, between 80 and 90 are Canadians. However, this includes patients seeking emergency/trauma care, which may be significant due to Detroit's proximity to the border. Although nearly all services and procedures were represented, many of the patients sought cardiovascular or lithotripsy care. "The numbers are not large, but the longer lines and fewer services offered in Canada are a factor in Canadian patients choosing to use us."
- *Johns Hopkins Medical Center, Baltimore, MD*—During fiscal year 1989, 28 of the 35,500 patients were Canadians. Seven of these patients were enrolled in a specific research program under one physician, and five had consulted a particular pediatric urologist, probably for treatment of genetic abnormalities. The remaining 16 patients were scattered throughout the hospital. "There is no stampede coming in from Canada."
- *Memorial Sloan Kettering Cancer Center, New York, NY*—From 1986–1988 twelve patients were Canadian. There was no pattern by province or age. Five of the twelve patients sought treatment for

bladder tumors. Some stays were paid for directly by patients. Others were paid by commercial insurance or, in one case, by Blue Cross.

Additional Comments—Don Potter, M.D., President of the Southeast Michigan Hospital Council, provided some interesting anecdotal information about Canadians' preferences in obtaining health care. Due to the Free Trade Agreement with Canada, a large number of Canadian nurses are working in Southeast Michigan hospitals. Most of them choose to receive their health care through the Canadian system, for which American employers pay premiums to the home province. However, these nurses are also offered Blue Cross and HMO plans which they frequently switch to when they anticipate the need for extensive or high-technology medical attention.

Wally Maher, former Director of employee benefits for Chrysler Corporation, mentioned that 10,000 Chrysler employees are Canadians working at a plant in Windsor, Ontario, just across the river from Detroit. "Despite numerous collective bargaining agreements, these workers have never asked for access to Detroit's excellent medical services," he said. He thought that these Canadian workers would have made an attempt to use American medical facilities, had it been important to them.

David Cow, M.D., Manager of Claims Policy for the Ontario Ministry of Health, felt that the access problems in Canada have been exaggerated. For example, between 1986 and 1988, 4000 coronary bypasses were performed in Ontario. Of 202 instances in which Canadians were treated in the U.S., 87.5 percent were emergency cases. Only 25 patients chose to be treated in the United States rather than use the Canadian health care system. "The cardiovascular problems mentioned in the press are a lot of hype. Some cities want improved facilities and publicize these cases as proof of a need for new equipment."

COMPARISON OF SELECTED COMPREHENSIVE HEALTH PLANS *

| | Basic Health Benefits For All (Kennedy/Waxman) (S.768/ H.R.1845) | National Leadership Commission | A Consumer-Choice Health Plan for the 1990's Enthoven & Kronick | Physicians for a National Health Program Himmelstein, Woolhandler, et al. |
|---------------------------------|---|---|---|---|
| | Employer mandate plus Medicaid (or public program) Expansion and Buy-In | Universal Coverage through employers who "pay or play" and a residual public program (UNAC) | Universal coverage through employer mandate plus public sponsored private insurance plus Medicaid | Universal coverage under a public insurance program. |
| Who's Covered and How | Employers are required to cover all employees working 17.5+ hrs/wk and consultants and contractors Employees working 25+ hrs/wk must accept coverage Others are eligible for or may buy-in to Medicaid State must subsidize private coverage for employed Medicaid eligibles and may do so for others | Everyone is required to have insurance through employer or self or public program (UNAC) Employers are required to cover all FT employees (35+ hrs/ wk) or pay tax to UNAC All employers also pay tax for PT workers and to finance unemployed in UNAC Individuals over 150% of poverty must pay tax to participate in UNAC | Employer required to cover FT employees (25+ hrs/wk) and to cover or pay tax to "public sponsor" for PT workers Everyone not covered by current public programs or employer may buy subsidized insurance through state level public sponsor | Everyone is automatically covered in one comprehensive public program Based on Canadian system |
| Private Insurance Provisions | Community rating by "regional insurers" for small businesses (25 employees or less) No exclusion for preexisting conditions Eliminates state mandated benefits Plus companion legislation below | Employers for whom tax is less than insurance costs may find UNAC more attractive than private insurance | Employers can buy insurance directly or through Public Sponsor for full costs No exclusion of preexisting conditions Plus companion legislation below | No role for private insurers |
| Small Business Subsidy | Subsidies for those small businesses whose compliance costs are in excess of 5% of gross revenues Very small and new businesses have a phase-in | Small Businesses (5 employees or less) and new businesses (under 3 years old) pay lower fees | Businesses of 25 employees or fewer pay a maximum 8% of payroll for insurance premiums | N/A |
| Effect on Medicaid | Eligibility expanded as described below plus improved benefits and reimbursement | Folded into UNAC | Maintained | Folded into insurance program |

COMPARISON OF SELECTED COMPREHENSIVE HEALTH PLANS *—Continued

| | Basic Health Benefits For All (Kennedy/Waxman) (S.768/ H.R.1845) | National Leadership Commission | A Consumer-Choice Health Plan for the 1990's Enthoven & Kronick | Physicians for a National Health Program Himmelstein, Woolhandler, et al. |
|---|--|--|--|---|
| Subsidy for Premiums for Low Income People | Under 125% of minimum wage, no premium for employer plan For unemployed up to 100% poverty eligible for Medicaid For employed up to 185% poverty states pays premiums Premium to buy-in to Medicaid for unemployed —3% of income, if between 100 and 185% of poverty —4% of income, if between 185 and 250% of poverty —5% of income, if above 250% of poverty | Under 150% of poverty Current Medicaid participants would have limited cost sharing | Individuals below 100% of poverty pay no premium; sliding scale up to 150% of poverty; above 150% poverty individual pays difference between subsidy and cost of plan (expected to be on average 20% premium) | No premiums for anyone |
| Benefits | Hospital care Physician care Diagnostic testing Prenatal and well-baby Limited mental health EPSDT for Medicaid children | To be developed by political process Illustrative plans for cost estimates: Basic: Inpatient, outpatient, labor, drugs, limited mental health Low: 14 days inpatient, drugs, outpatient, lab, well baby | Basic benefits in HMO Act: Physician, inpatient and outpatient hospital services; medically necessary emergency services; crisis intervention mental health services; alcohol and drug medical and referral services; lab and radiologic services; home health and preventive services | All medically necessary care Acute care Rehabilitative care Long-term care Home health care Mental health care Dental care Occupational health care Prescription drugs and medical supplies Preventive health care |
| Deductible | Above 100% of poverty: \$250/person \$500/family or actuarial equivalent Below 100%: Medicaid pays | Illustrative plan: Basic: \$100/person Low: \$50/person \$150/family | Up to \$250/individual (except possibly in HMO's) | None |
| Coinsurance | Above 100% of poverty: 50% outpatient psychiatric 20% all services but prenatal and well baby or actuarial equivalent Below 100%: Medicaid pays | Illustrative plan: Basic: 20% Low: none for inpatient | Up to 20% | None |
| Cap on Out-of-Pocket Expenditures | Above 100% poverty: \$3,000/family or actuarial equivalent Below 100% poverty: Medicaid pays | Illustrative plan: Basic: \$1,000/ individual; \$3,000/ family Low: No limit | Up to 100% of annual premium | N/A |

COMPARISON OF SELECTED COMPREHENSIVE HEALTH PLANS *—Continued

| | Basic Health Benefits For All (Kennedy/Waxman) (S.768/ H.R.1845) | National Leadership Commission | A Consumer-Choice Health Plan for the 1990's Enthoven & Kronick | Physicians for a National Health Program Himmelstein, Woolhandler, et al. |
|----------------------------------|---|---|--|---|
| Cost Containment Provisions | Economics of scale and community rating said to reduce insurance costs for small businesses Managed care option | Each state UNAC gets a prospective budget "Innovative purchasing" by states UNAC sets rates for providers which other payers may use Malpractice reforms Practice guidelines Managed Care Individuals incentives through more information and cost sharing | "Managed competition" to create cost- conscious choice of "managed care" plan, to encourage growth of cost-effective systems of care Cap on tax exclusion for premiums fixed-dollar employer contribution toward insurance premiums, and choice of plans to encourage cost-conscious choice of plans by consumers Surveillance and active management by employers and public sponsors, plus risk- adjusted premiums to focus competition on efficiency, not risks | Reduced administration costs—8.2% cost savings National health costs capped at percent of GNP Resource allocation through planning Global budgeting for institutional providers Individual providers opt for salary or negotiated fees Capitation option |
| Health Care Quality and Value | Clinical practice guidelines developed PRO review | Develop health outcome data base Clinical guidelines Technology assessment | "Health outcome" data base created to encourage "wise choices" by companies and consumers Technology assessment | Review boards Technology assessment Regional planning |
| COSTS | | | | |
| Employer Obligations | Pays 100% premium for those under 125% minimum wage Pays 80% premium for 25+ hr/wk employees (and proportional contribution for 25- 17.5 hr/wk workers) Total costs estimated at \$33b Net cost after offsets is \$18b | 75% of premium for FT workers or for each worker not covered in health plan: on wages up to \$45,000, approximately 9% Every employer pays approximately .6% of payroll to finance unemployed through UNAC Total cost not estimated | For FT employees 80% of premium of average plan plus for each worker not covered in health plans, pays 8% of payroll up to \$22,500 Total cost not estimated | During a transition period: No new expenditures envisioned Tax on employers equal to previous year's statewide total for employer's spending for health costs go to plan Total cost equal to current expenditures |

COMPARISON OF SELECTED COMPREHENSIVE HEALTH PLANS *—Continued

| | Basic Health Benefits For All (Kennedy/Waxman) (S.768/ H.R.1845) | National Leadership Commission | A Consumer-Choice Health Plan for the 1990's Enthoven & Kronick | Physicians for a National Health Program Himmelstein, Woolhandler, et al. |
|-----------------------------------|--|---|---|--|
| Individual Obligations | Employees pay 20% of premium and all other cost sharing except as subsidized Medicaid buy-in costs as stated Total costs not estimated | Pay up to 25% of health premiums To purchase UNAC, if otherwise uncovered, pay approximately 2% of adjusted gross income (AGI) up to a ceiling Every employee (over 150% poverty) pays approximately .6% of AGI to finance unemployed through UNAC All pay other cost sharing Total cost not estimated | Pay up to 20% of premium: if company contribution is greater than cap 80%, excess is taxable; if not in employer plan, pays 8% of family income up to a ceiling All pay other cost sharing (if there is any) | During a transition period: No new expenditures envisioned Tax on individuals equal to amount now spent for premiums and out- of-pocket costs goes to plan Total cost equal to current expenditures |
| Federal Government Obligations | Current programs plus cost associated with Medicaid expansion and mandate Total cost not estimated | All current Medicaid dollars go to UNAC plus additional lost tax revenues of \$12.9b | Cost estimates: Net increase of expenditures of \$.3b | During a transition period: No new expenditures envisioned All current state and federal health expenditures go to plan Total cost equal to current expenditures |
| Companion Legislation | Full tax deductibility for self-employed premiums Simplify Section 89 rules and waivers for firms offering BHB plan | Malpractice reform | Repeals state mandates; section 89 COBRA; Eliminate health care benefits from cafeteria plans | Not addressed |

* Briefing paper prepared for Commissioners by Judith G. Waxman, September 28, 1989.

An Overview of Issues in Estimating the Market Potential for Private Long-Term Care Insurance *

Estimating the impact and the costs of public policy options always entails making many assumptions. This is true for both access to health care and long-term care. However, because options for altering the financing of long-term care are more sensitive to what happens over many years, projecting the future is a critical issue for long-term care.

The purpose of this paper is to discuss the relative merits of developing projection models, the importance of some of the key assumptions that must be made, the particular problem posed by estimating future demand for long-term care insurance, and a very brief overview of two alternative long-term care public policy models. This paper is not intended as an evaluation of the potential for private insurance.

Public policy models are bound to be controversial. Too often results that do not conform to expectations lead to rejection of the model while results that do are discussed without caveat. Neither perspective is constructive. Certainly no computer generated model can know what the future holds, while rejection of the model leaves us with few alternatives to assist public policy decisions. Our understanding of the limitations of a model will make it easier to understand the public policy trade-offs and options. Critical to making the model useful is a very detailed evaluation of how the model's results are affected by the specific assumptions. The relative degree to which results change (sensitivity) provide an understanding of the key assumptions and how important they are. Using upper and lower bounds for the major assumptions helps to delineate a range of possible outcomes.

Why Use a Public Policy Model?

Past and present are prologue to the future; but not necessarily in a simply derived manner. It is not clear whether the elderly of tomorrow will look at all like the elderly of today. Therefore, when it comes to estimating the future of long-term care in general, and the potential for long-term care insurance, in particu-

lar, the present is not likely to be an accurate representation of the future.

The fundamental flaw in trending the present forward is that behavior changes over time, and even more complicated, it will change in response to changes in public policy. Trending assumes that behavior does not change and therefore poses a problem. For example, applying current service use by demographic groupings to projections of the future necessitates the assumption that the prevalence rates remain the same—that is, the long-term care needs of today's 80 year old widow will be the same for tomorrow's 80 year old widow. In lieu of any other information, this may be the best we can do, but it is important to recognize that tomorrow's 80 year old widow might not look like today's. Furthermore, projections of how many 80 year old widows there will be may not be correct.

Limitations in our ability to apply the present to the future, however, do not necessarily imply that developing the tools to evaluate the future for purposes of public policy is not a worthwhile endeavor. A model has the capacity to systematically evaluate many of the interrelationships as perceived to be affecting behavior. It therefore enables researchers to test the relative importance of these relationships. As a research tool, such models offer the opportunity to carefully think through, and estimate our understanding of these relationships and to establish a focused research agenda that can assist public policy.

The more realistic the model, the less sensitive the outcomes will be to slight differences in assumptions. Testing this sensitivity is critical in developing the model and in understanding its limits. Generating such a model must be an ongoing endeavor, as research—guided by the focus of the model—brings to light a clearer understanding of these relationships.

The relative ease and our temptation to view a single set of results encased in a table as the "truth" can easily mislead public policy. As a policy tool, therefore, it is important that the limitations of modeling be understood and that the range of outcomes

* Briefing paper prepared by Robert B. Friedland, for November 8, 1989, working meeting.

associated with various assumptions be used as indicators, rather than definitive answers. With the appropriate caution, models can be used as important inputs in the decision making process.

Key Assumptions in a Long-Term Care Model

To be useful, a model should be able to project how much the cost of long-term care will change and the distribution of the financing of this cost, assuming no change in public policy. This is usually called the "base case." While the model's results after the introduction of a specific public policy option into the model can be informative, the comparison with the base case is much more relevant. It tells you how much difference the policy made. Important considerations in evaluating the impact of the policy change is how total costs change and the distribution of that change in total cost. The array of assumptions that are critical to posing hypotheses about the future include:

- the distribution of the population;
- how the change in the population will affect the need for and demand of long-term care services and how this will affect the cost of long-term care services;
- how the economy will change and how this will affect the economic well being of those who are at risk of needing long-term care;
- how individuals' income and assets will affect the demand for and supply of private long-term care insurance policies and consequently the price and ownership of such policies.

The size and distribution of the population depends on fertility and mortality rates. The size and distribution of the population, in conjunction with disability rates, have a direct effect on long-term care service use. The demand for long-term care services, in conjunction with the supply of services, affects the cost of services. Both the feasibility of purchasing private insurance and the demand for long-term care insurance depend on the economic resources of the population, the proportion of one's resources that can be reasonably devoted to such policies, the price and adequacy of the policies, and the willingness of consumers to purchase policies.

Demographic Factors, Service Use, and the Cost of Services—

1. Fertility and Mortality Rates—We know a great deal about fertility and mortality rates and can, under the assumption that fertility and mortality rates con-

tinue along the same path, project future age and sex distributions of the U.S. population. Since part of the future distribution of working adults and elderly have already been born, there is a fairly well known lead time on these projections. But slight variations in either fertility rates or mortality rates can have substantial impacts on the projected age distributions. Our ability to project the future elderly population has historically been frustrated by an inability to foresee improvements in mortality rates.

2. Disability—Clearly, the potential for needing long-term care depends on morbidity or disability rates (as well as the severity of that disability and living arrangements). It is easiest to assume that disability rates by age and sex, and marital status in the future will remain the same; but the size of the projected long-term care population will directly depend on assumptions of mortality rates. If mortality rates are assumed to continue to decline (more people at each age and sex group are assumed to survive) and disability rates remain the same, then more people will need long-term care. The literature on the relationship between mortality and morbidity is not conclusive. That is, we do not know if people are living longer and healthier or surviving strokes and heart attacks only to need assistance from others to function on a daily basis.¹ There are data to support both notions.

It is certainly impossible to project medical breakthroughs on major chronic debilitating conditions. But, delaying the onset of Alzheimer's Disease or some other related dementia, or controlling incontinence with drug therapies, for example, would substantially alter the long-term care needs in the future.

3. Long-Term Care Service Use—We know relatively little about the course of long-term care over an individual's life. Furthermore, what we do know is based on current financing arrangements. How we have financed long-term care has had a tremendous influence on the organization and delivery of care (as well as the quality of that care). Very recent data bases provide new insights into utilization and caregiving arrangements, but most of this information is at a single point in time or, at the most over a fairly limited period of time.

Projecting is complicated by the fact that the very public policy under investigation may, by itself, also alter service use. Service use may change in several

¹ See for example Kenneth G. Manton, "Past and Future Life Expectancy at Later Ages: Their Implications for the Linkage of Chronic Morbidity, Disability, and Mortality," *Journal of Gerontology* (September 1986): 672-681; and James F. Fries, "Aging, Natural Death, and the Compression of Morbidity," *New England Journal of Medicine* (July 17, 1980): 130-135.

ways. Current use has been limited by the availability of services and the ability to pay for services that are available. Increased financing may make these services available, and coverage (which subsidizes the cost of the service) will enable more people to avail themselves of the services. Second, service use may increase because the availability of services may alter the type and/or quantity of care provided by family and friends. Finally, to the extent that informal caregivers may not be available to provide care in the future (e.g., due to decreased fertility rates and increased labor force participation rates among women), there will be a greater demand for formal services.

4. Cost of Long-Term Care—A critical assumption is the expected cost of care. Both the demand and supply of services will affect the price and cost of paid care. The demand is dependent on the population, disability rate, utilization rate, and the financing (including reimbursement policy). The supply of care also depends on financing and, in particular, reimbursement, as well as the availability of people to work as caregivers, care coordinators, administrators, etc., in providing long-term care.

The interesting problem posed by rising prices is that the market responds in countervailing ways. The higher the reimbursement relative to the cost of providing care the more likely the supply of services will increase. However, depending on how sensitive potential users are to the price, the higher the price, the less the demand for that service. Our understanding of these interactions, especially when we compound the complexity of the issue with different kinds of services that can be substituted for one another, is relatively limited.

Key Issues Concerning Estimating the Potential for Private Long-Term Care Insurance—A number of assumptions must be made to estimate the potential private long-term care insurance market. Some of the more critical issues include how will the emerging private market change—without any public policy intervention—the potential in the future of individuals to afford policies, and the relationship between affordability and the decision to actually purchase a policy. Affordability depends on the income and assets of consumers as well as the price of the insurance policy.

1. Predicting the Future From the Emerging Private Long-Term Care Insurance Market—Private insurance for some long-term care has been available for a decade or so. Most large health or life insurance companies did not express any interest in developing policies until after 1985. Since then, the market for long-term care insurance has changed dramatically. The number of policies sold has increased from virtu-

ally zero a decade ago to perhaps over 1.3 million, with most of that growth in the last two years. The estimated number of policies sold increased from 2.8 percent to 5.4 percent of the elderly. By today's standards, many of the policies sold for long-term care even 3 years ago would no longer be considered adequate long-term care insurance policies. These recent changes reflect insurer competition, regulator concern, and consumer preferences in the development of this market.

The most promising development for the expansion of the private insurance market has been employer interest. Employers have the potential to focus employees' attention on the need to consider long-term care in their retirement planning. Furthermore, employment based policies have less administrative and marketing costs than individually sold policies. Currently about 35 employers provide (or are about to provide) access to a long-term care insurance policy that costs about 25 percent less than the same policy sold on an individual basis.

Most employers that have established plans have made the insurance available to their employees and their spouses, retirees and their spouses, and the parents of employees or their spouses. Except for two union negotiated pilot studies, premiums have been employee-paid.

How far will this trend go? Will employees and employers begin to restructure employee compensation to include an employer payment of premiums? (Many employers do provide more conventional benefits—pensions and health insurance—but about half of all workers are not covered by a pension and 15 percent of all workers are not covered by employer-provided health insurance.)²

The rapid developments, as well as the infancy of this market pose serious problems for projection purposes. Data are insufficient to know how these policies (and their price) will change and how employer and purchaser attitudes will change in the future.

2. The Importance of Income and Assets: Affordability and Demand for Long-Term Care Insurance—Both the state of the economy and how people have fared over the projection period are very critical components of any projection endeavor. Retirement income, both from employee pensions and social security, is directly related to work histories and the economy

² Joseph Piacentini and Timothy Cerino, *EBRI Data Book on Employee Benefits* (Washington, D.C.: Employee Benefit Research Institute, forthcoming); and Deborah J. Chollet, "Uninsured in the United States: The Nonelderly Population Without Health Insurance", 1986 (Employee Benefit Research Institute, 1988).

during those years. The amount of assets accumulated, too, are directly related to these factors, as are savings behavior and inheritances.

Income and assets are important in making decisions about receiving long-term care, purchasing long-term care insurance, and whether or not the need for long-term care will entail any Medicaid expenditures. Underestimates of savings, for example, will lead to an increased likelihood of disabled people needing assistance from the state Medicaid program and an underestimate of the potential of long-term care insurance. We know that savings behavior varies by age cohort and by sex and marital status; what we do not know is how savings behavior will change.

Most discussions on the potential for long-term care insurance center on the question of what is affordable. Affordability indicates who *could* purchase long-term care insurance; demand, however, is the indicator for willingness to actually purchase. Changes in demand could affect the supply and the price of insurance. Lacking appropriate data to determine demand, affordability is often used as a proxy for the market potential. But affordability is a subjective concept.

What is a reasonable assumption for affordability—two percent, five percent, ten percent of income? How important are the level and type of assets in influencing an individual's willingness to purchase a policy? There are no data other than preference polls from which to gauge the demand for insurance relative to family income and assets. Furthermore, affordability may be different over various stages in a individual's lifetime.

A comparison of two measures of affordability in the current population (age 45 and older), illustrates how estimates may vary. Under an affordability assumption that people who are not now disabled would purchase long-term care insurance if they had at least \$10,000 in assets and premiums were not more than 5 percent of their *income*, 54 percent of the population age 45 to 64 and 7 percent of the *current* population age 65 or older would be able to afford a \$50 a day nursing home benefit and a \$25 a day home care benefit long-term care insurance policy (with a 60 day deductible).

If, instead, affordability were based on "discretionary" income *and* assets (annuitized assets and income with necessary expenditures, such as food, shelter, clothing, medical expenses, and taxes, etc., subtracted out) and if affordability were defined as 20 percent of discretionary income and assets, then 54 percent of

the nonelderly and 4 percent of the elderly would be able to afford such insurance at age 65 or older.³

In this example, more than half of the nonelderly were considered capable of "affording" a long-term care insurance policy that would pay \$50 a day for nursing home care, yet only a negligible portion of this population have actually bought such policies. "Affording" a policy and "demanding" a policy are two different things. This may reflect the lack of consumer awareness, dissatisfaction with what the policy offers, an unwillingness to spend 5 percent of their income, or an unwillingness to purchase a policy with this value.

In the future, based on current costs of long-term care insurance, the potential for a large segment of the population to have purchased long-term care insurance depends on (1) how many people will purchase long-term care insurance during their working years and continue paying premiums for the rest of their life and (2) how many people who do not buy such insurance prior to retirement will be willing and able to purchase such insurance after they do retire.

Most policies are marketed as lifetime decisions. That is, the price does not reflect the current risk of needing long-term care, rather the price is based on an average lifetime price. As a consequence, when one has been paying premiums for some time, the price of the policy is low relative to the risk later in life, but high relative to the risk of needing long-term care in the earlier years. To retain value in the policy, however, policy holders must continue to pay premiums (although some insurers are considering policies that refund part of the premium paid). Insurance purchased at age 30 under these financing arrangements cost a tenth of what it costs at age 65.⁴

Will a 50 year old, who might not need any long-term care for 25 years, be willing to risk purchasing a policy that will pay \$50 a day for a nursing home stay and \$25 a day for home health care? Consumers face several risks in deciding on a policy, including that his or her expectations about inflation and the future cost of long-term care will be wrong, that he or she will not be able to afford to continue to pay the premium, or that the insurer will not honor the policy (either because they are no longer in business or be-

³ Tabulations using the Survey of Income and Program Participation (SIPP) in Friedland, *Facing the Costs of Long-Term Care*, (Washington, D.C.: EBRI, forthcoming).

⁴ In addition to compounding interest, premiums are currently so much less because it is assumed that a certain percentage of policy holders will drop the policy years before the risk of needing long-term care is even noticeable. If these "lapse rates" do not hold (or decline) then the differential in premiums by age will increasingly depend on expected rates of return in premium reserves. Furthermore, declining lapse rates, holding all else constant, will lead to increased premiums.

cause that type of policy was cancelled). Consumer preferences could be influenced by employer-paid premiums or by government regulation; both of which are uncertain. As for the elderly, their future behavior depends heavily on their income and assets.

Projections of the income of the elderly in the future from the Pension and Retirement Income Model (PRISM) suggest that for married couples who turn age 67 between 2012 and 2021, real Social Security income is expected to increase nearly 35 percent and employer sponsored pension income is expected to be more than double the Social Security income and employer-sponsored pension income among current retirees. For unmarried individuals, Social Security income is projected to increase 42 percent and employer-sponsored pension income by 81 percent. The Dynamic Simulation of Income Model (DYNASIM) suggests that mean retirement income of the elderly couples will, on average, increase 79 percent by 2010 and 128 percent by 2030. For unmarried men, mean retirement income is projected to increase 57 percent by 2010 and 118 percent by 2030; for unmarried women, the corresponding rates of increase are 40 percent and 113 percent, respectively.

The more optimistic DYNASIM projections suggest that, in 2030, about 80 percent of unmarried women and 60 percent of unmarried men will still have incomes of less than \$20,000 (in 1988 dollars)—leaving, for the most part, premiums for long-term care insurance in excess of 5 percent of income for more than 70 percent of the unmarried elderly in 2030 (assuming the purchase of insurance did not occur until after age 64).⁵ How many of these elderly would have already purchased long-term care insurance (prior to retirement) is not attainable without additional modeling. Assets of the future elderly are unknown.

Description of Two Alternative Public Policy Models

Two competing models that are in process include the Brookings/ICF Incorporated Long-Term Care Model and the LifePlans, Inc., Long-Term Care Model. Both models have been developed with the intention of estimating the effects of public policy options on the financing of long-term care. The Lifeplans, Inc. model was initiated long after the

Brookings/ICF, Inc. model was first completed and is built in an entirely different way.⁶

The Brookings/ICF, Inc., Long-Term Care Model—The results of an earlier version of the Brookings/ICF, Inc. microsimulation model were widely disseminated in a policy study by Alice Rivlin and Joshua Wiener in 1988.⁷ For many different reasons, their book has received a great deal of attention. It has been praised for raising the alarm that the cost of long-term care is going to increase, and for the attempt to include, as a criterion for public policy evaluation, the impact of private financing alternatives on current public programs.⁸ The latter is an explicit attempt to measure the trade-offs in social policy associated with public subsidies (that is, who benefits and at what expense). On the other hand, the book did not provide a sufficiently complete set of sensitivity analyses to enable the reader to understand how sensitive the results are to specific assumptions. Other fundamental criticisms of the study center around the specific assumptions used, in particular the long-term care inflation rate, and the assumed direct corresponding linkage between need, demand, and supply.

The Brookings/ICF model builds upon the PRISM model of projecting retirement income by adding a component that accounts for disability, the use of long-term care services, and the sources and levels of payment for those services. Basically, the model takes individuals age 25 and older in 1979 and simulates the rest of their lives using probabilities compared to a computer generated random draw. For each life “event,” a random number (between 0 and 1) is drawn and compared to the probability of that event. If the number drawn is less than the specific probability, then that event occurs; if the number is greater, then that event does not occur. Events include: changing jobs, participating in a pension plan, becoming 100 percent vested in that pension, contributing to an individual retirement account, getting married, getting divorced, having children, leaving the labor market to raise children, re-entering the labor market, retiring, becoming disabled, needing long-term care services, entering a nursing home, receiving home health care, and dying. Each individual in the model faces all of these events (and more) for a simulated year. The probabilities they face are specific to the individual’s age, sex, income and marital status in that simulation year. The first part of the model, PRISM,

⁶ Much of this model is not yet complete. Preliminary and confidential results have only been shared with a small group of technical advisors.

⁷ Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?* (Washington DC: Brookings Institution, 1988).

⁸ See for example Christine Bishop, “Long-Term Care: Sharing of the Burden,” *Science*, (243) 1738–1739, Mark V. Pauly in *Health Affairs*, (Fall 1988), 169–172; and an unpublished response by the Health Insurance Association of America, May 1988.

⁵ From Sheila R. Zedlewski, Roberta O. Barnes, Martha K. Burt, Timothy D. McBride, and Jack Meyer, “The Needs of the Elderly In The 21st Century,” The Urban Institute, DRAFT, July 1989, Figure 4.5.

takes the individual out to age 65. At that age, an individual's marital status and retirement income have been determined by their experiences within the model.

In the version of the model used for the Rivlin and Wiener study, the decision to purchase long-term care insurance was made at age 65. It was assumed that insurance was purchased as long as premiums were below a specific percentage of income for those with a minimum level of assets. Assets from the 1983 Survey of Consumer Finance were statistically matched to those who had retired in the model. What this implies is that a lifetime of savings behavior of 65 year olds from an earlier period are assumed to be the same for future cohorts of 65 year olds. To the extent that different cohorts are more or less inclined to save, and have the ability to save, this will bias future projected levels and types of assets. Furthermore, the model did not incorporate any savings from retirement age forward.

From age 65 forward, individuals were aged and then faced events relevant to long-term care, (death, disability, long-term care service use). Income, assets, and the ownership of long-term care insurance determine who will end up paying for the care that was assumed to be purchased. The long-term care use probabilities were derived from the 1982 National Long-Term Care Survey and the 1977 National Nursing Home Survey.

Since publication of the book, more recent—and in some cases, more appropriate—survey data have become available. The model has been recently updated to incorporate the asset data from the Survey of Income and Program Participation (SIPP), and the service use probabilities based on the 1984 follow-up and expansion of the 1982 National Long-Term Care Survey and the 1985 National Nursing Home Survey. More importantly, the model's long-term care insurance policies have been updated to include an inflation protected benefit and the decision to purchase insurance before retirement has been incorporated. In one version of the current model, employers are as-

sumed to increasingly make available access to a long-term care insurance policy and in another, employers pay for part of the premium.

Despite these improvements, the model still faces some important limitations. In particular, the model does not incorporate any savings behavior after age 65, there are no long-term care service supply constraints, which means that the inflation assumptions become very critical, we have incomplete information on nursing home lengths of stay, and the model is tied to individuals age 25 and older in 1979—limiting the time in which future projections can be considered reliable.

The model is tied to individuals in 1979 because the May supplement to the Current Population Survey was matched to Social Security records to enable the model to generate Social Security income from actual work histories. This means that to obtain results for 1989, the model has had to produce 10 years of simulations. Thus, for the first 10 years, it is relatively easy to see how well the model has been doing compared to actual data, but to go 10 years out from today the model has to simulate 20 years. Furthermore, because of this starting point, only the first half of the baby-boom generation is incorporated in the simulations.

The HIAA/LifePlans, Inc., Long-Term Care Model—The Health Insurance Association of America has helped to finance an alternative long-term care public financing model. Instead of simulating all of life's events, this model accounts for behavior mathematically, using data on population and market characteristics in solving a variety of important behavioral equations. In a joint venture with Lifeplans Incorporated and economists at Brandeis and Boston Universities, this approach models the various markets associated with long-term care. This includes the supply and demand for long-term care services and the supply and demand for long-term care insurance.

Details on the model are not available, since the model is not yet complete, and nothing has yet been published.

Converting Life Insurance Benefits to Long-Term Care Benefits *

In the October 5, 1989 Commission hearing, Richard Schweiker, President of the American Council of Life Insurance, made some comments that raised questions and perhaps some confusion. I thought I should sort out three questions that were raised. Specifically, I would like to address the question of the potential to unleash \$4.5 trillion for long-term care, the Federal tax consequences, and the need for tax clarification.

On the Question of the Potential of the \$4.5 Trillion

The \$4.5 trillion represents potential life insurance liabilities with respect to individually purchased policies actually in force. Premiums collected for these policies do not approach \$4.5 trillion (which is nearly the entire Gross National Product). In 1989, an estimated 103 million individuals held individual whole and term life insurance policies whose death benefits would be \$4.5 trillion if all policy holders were to have died in that year.

The potential suggested by the \$4.5 trillion these policies represent *assumes that all current policy holders* pay the slightly larger premium for the long-term care rider and hold on to the policy until they need long-term care. It is not certain how many people would do that. Converting the death benefit to a long-term care benefit is not costless to the consumer. The policyholder who needs long-term care loses an equal value of their death benefit. While this flexibility could be useful to all policyholders, it would be most useful to those who no longer need the protection of life-insurance, that is, the older population.

Survey data tabulated by the ACLI suggests that in 1987, while 18 percent of the policies were held by those age 65 or older; 32 percent of the non-elderly and 49 percent of the elderly have whole-life or universal insurance.

The potential of the policy to actually cover long-term care is primarily based on the value of the death benefit. While the likelihood of having a policy does not vary very much by income, the value of the death benefit does. In 1984, median coverage was \$42,000 among those with household income in excess of \$35,000 but less than \$7,300 among households with less than \$17,500 in household income. Median income of the elderly in 1987 was \$14,334. According to the ACLI, the average death benefit for permanent life insurance policies *sold in* 1988 was about \$50,000. At the moment about 11 life-insurance companies sell policies with long-term care riders. Most of the policies allow policy holders the use of the entire death benefit; although there are a few that will limit the use to perhaps half the death benefit. Except for the "dread disease" or terminal illness policies the death benefit is paid in increments of a certain percent per month, typically 2 percent per month. That is, if one is holding a policy with a \$50,000 death benefit, the long-term care insurance potential in a typical policy would be \$1,000 a month for 50 months. (The monthly average cost of nursing home care is \$2,000.)

On the Tax Consequences of This Conversion

Whole or universal life insurance consists of a death benefit and a cash value that arises by virtue of the level of premium payments (premiums are greater than the risk of dying in the early years and less than the risk of dying in the later years). The cash value is, however, available as a loan or if the policy is severed, outright. In this sense, whole or universal life insurance is life insurance whose death benefit is not taxed and a savings instrument whose earnings are not taxed as they accrue but is subject to taxation if used. Under current law, beneficiaries do not pay income taxes on the death benefit they receive (and there may be, however, estate taxes). If the policy holder had decided to cash in their life-insurance policy, the cash-value less the premiums paid would, however, be subject to income taxes.

Mr. Schweicker indicated that having an individual convert a death benefit to a long-term care policy would not cost the federal government any loss in tax

* Memorandum to Commissioners from Robert B. Friedland, November 18, 1989.

revenues. This is correct if all life-insurance policies are not cashed in prior to death. However, if a policy would have been cashed in, but because of the rider is not, then there is a loss in tax expenditures. That is, if one were to cash in their life-insurance policy—even to purchase long-term care insurance—this transaction could result in some additional tax revenues. (However, if the cash is used for medical reasons, those expenditures—in excess of 7.5 percent of adjusted gross income—could be itemized as a durable medical expense.)

On the Need for Tax Clarification

It should be pointed out that life insurance riders for long-term care do not necessarily need tax clarifi-

cation to exist. There may be some controversy at the state level that clarification would assist, but by and large, such policies could be (and are) sold under the current tax code. The clarification desired, however, would help insurers in marketing these policies (and the policy holders who receive long-term care benefits under the policy). Current tax law does not define long-term care and therefore leaves the treatment of long-term care and long-term care insurance ambiguous. It is not clear under current tax law whether the benefit payment received must be reported as taxable income. Treating these benefits as health benefits would clarify that the benefits are not subject to federal income taxes.

Adding a Long-Term Care Option to Medicare *

One approach to expanding long-term care coverage would be to offer individuals over age 65 an option to limit Medicare acute care coverage in order to pay for a long-term care benefit. Individuals could choose what mix of acute and long-term care benefits they want.

The Tradeoffs

At least part of the costs of any long-term care insurance could be defrayed by raising the deductibles for Medicare's existing acute care benefits. The costs could be spread over both Parts A and B, although Part A is more complicated and could result in multiple deductibles as it is currently configured. Simpler and perhaps a more manageable mechanism would be to raise only the Part B deductible.

Since so many beneficiaries now exceed the Part B deductible, raising it just a little will yield considerable revenues. As the deductible amount increases, however, the "return" from this process declines. Fewer and fewer beneficiaries are likely to have such high physician expenses. For example, increasing the Part B deductible to \$400 from its current \$75 would save approximately \$172 per enrollee in 1991. Raising the deductible to \$600 would save approximately \$249 to be applied to a long-term care benefit. Pushing the deductible to \$800 would raise \$314 per enrollee (unofficial CBO numbers).

What will it cost to offer limited long-term care benefits to the elderly? The cost of a one year "front-end" program (covering the first year of nursing home care) would be approximately \$400 per enrollee. The public cost of a nursing home benefit that would begin after a two year waiting period ("back-end coverage") would be approximately \$600 per person. (These are actually 1993 costs expressed in 1989 dollars—but they offer a reasonable benchmark for comparison with what could be raised from Part B deductible increases.)

These figures suggest that it would be difficult to fund even very restricted benefits from a Part B deductible increase. To do so would likely require a Part B deductible of \$1000 and a Part A deductible increase as well. At that level, individuals opting for the long-term care option would expose themselves to considerable acute care risks each year.

Another approach could be to allow individuals to pay part of the costs through a higher premium and part through an increase in the Part B deductible. Beneficiaries who chose such an option could then be assessed an add-on to their Part B premium. The risks of high acute care costs in any year would be lessened and spread more evenly over time.

Who is Likely to Buy?

Higher income individuals who can afford to supplement the limitations on acute care benefits may be likely to choose the long-term care option. However, such individuals may also be able to afford more comprehensive policies through the private sector. A limited benefit might appeal to moderate income elderly persons who cannot afford comprehensive, private plans but who would like a limited benefit.

Adverse Selection—One danger is that those who find it most to their advantage to choose a long-term care option may be those at greatest risk—creating a problem of adverse selection.

In theory, at age 65 there is a large pool of individuals in good health who, if they opt for long-term care coverage, could result in a reasonable risk group for the program. Most individuals are reasonably healthy at age 65 and do not begin needing long-term care support until they are in their late seventies. But that very fact may result in such individuals opting for the acute care coverage since they are likely to make use of such insurance in their sixties and seventies.

Even at age 65, a considerable portion of Medicare beneficiaries may have a sense of the likelihood of need for long-term care. For example, each year ap-

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proximately 180,000 persons who are receiving Social Security disability benefits turn 65. In addition, others who may not have qualified as totally and permanently disabled under Social Security may also have some disability that is likely to result in eligibility for long-term care benefits over time. Persons with chronic conditions such as arthritis or diabetes may also be able to anticipate future needs for long-term care services.

It would be unfair to prevent such individuals from participating; indeed, giving such persons access to coverage would seem to be a goal of the program. Nonetheless, if these individuals chose the long-term care option, the group could start out with a very adverse risk pool that could quickly escalate costs and discourage others from participating. Private insurers who could exclude individuals in poor health could offer better plans to those in good health, further affecting adverse selection.

In addition, to offer stability to the program, considerable limits would need to be placed on how often, if ever, an individual would be able to switch. A one-time only decision would certainly be the simplest to administer and result in the least amount of adverse selection. Another approach might be to only permit a one-time choice but offer some flexibility by allowing individuals to postpone the decision until age 70, for example. In such a case everyone would start out in the traditional Medicare program, but be able to switch to the long-term care option up until they reach age 70. The premium cost and/or deductible tradeoff would rise over time to reflect the greater actuarial costs of allowing such choice.

More frequent switching—for example, offering the choice every five years—could also be allowed, but could substantially drive up the costs of the program. Under such a scheme, there would be fewer years to build the equity in the long-term care option and thus it would require much greater tradeoffs against the acute care benefits. In addition, if considerable switching is allowed, private insurers might be less willing to offer supplemental or wrap-around policies—particularly for long-term care.

Who Benefits?—If the deductibles necessary to support the program are as large as it appears, the takeup of this option is likely to be quite small and limited to individuals who know that they will need long-term care. This would certainly be an important benefit to such individuals because they probably will never be able to purchase such protection in the private market. What is largely unknown is the perception of the value of the tradeoff between a \$1000 or more de-

ductible on the acute care side for a limited nursing home benefit.

Another possible group opting for long-term care coverage would be individuals who have good wrap-around coverage from employers or as retirees. They would likely view a long-term care benefit as a way to avoid duplicate coverage that they now have on the acute care side. Similarly, some individuals may simply prefer to buy private acute care policies in exchange for some long-term care coverage. These would likely be relatively high income beneficiaries who could afford to pay another \$500 or more a year in premiums.

Who Loses?—In theory, the Medicare option would be cost neutral and no one should lose from this plan. In practice, however, there may a risk of destabilizing Medicare. Acute health and long-term care insurance represent very different types of insurance risk and require different streams of benefits over time. It would be difficult to initially set an appropriate tradeoff between the acute and long-term care options so as to ensure actuarial fairness. Windfalls or shortfalls could be created for Medicare over time, requiring adjustments that could throw the system out of balance. The premium for long-term care insurance might rise more rapidly than anticipated, for example, generating not only a crisis for Medicare, but also for beneficiaries as well.

If costs rise faster in one program or the other, the perception of inequity in treatment could create considerable discontent on the part of beneficiaries. Even if the financial balance could be kept, pressures to expand coverage might be great from individuals in one option who “guessed wrong” to be able to switch or at least to receive some relief.

Finally, another group of losers could be the moderate income individuals enticed to opt for long-term care coverage. Several years of high out-of-pocket acute care costs could wipe out their resources so that they would be eligible for Medicaid coverage and never actually benefit from the long-term care protection.

Subsidizing the Option

Perhaps the strongest criticisms of a Medicare option of this sort centers on how few individuals will benefit unless some sort of a subsidy is offered to those of modest means. An option that would require substantially higher out-of-pocket costs for acute care would pose untenable choices to many of the elderly.

For example, a single woman with an income at 200 percent of the poverty line (about \$12,000) is likely to have out-of-pocket costs of about \$2000, on average. That represents about 17% of the person's income. Another \$400 in out-of-pocket costs or premiums would increase that total to 20%—likely to be beyond the budget of that individual. This person would be better off to rely on Medicaid for her long-term care needs. The issue becomes more complicated for those with somewhat higher incomes, but for whom resources are still stretched.

A simple long-term care option to Medicare could be offered as part of a package that also improved long-term care coverage for those at lower incomes in order to provide some help to all elderly persons. Such a combination could be, but would not need to be, achieved by giving the Medicare optional coverage to low income persons (with no resultant reductions in acute care coverage), and allowing a subsidized buy-in to those with somewhat higher in-

comes. By putting the coverage together in a single package, the pool of persons in a public plan would be increased, probably lessening adverse selection that would occur without any subsidized participation. Alternatively, such an option to Medicare could simply be offered at the same time as a Medicaid improvement, keeping the two programs separate but arguing that all the elderly would now have access to some federal long-term care protection.

How could such a subsidized plan be offered? A buy-in of the deductibles, premiums and copays for Medicare acute care is now being phased in for those with incomes below the poverty level. This could be extended to the long-term care option. And individuals above poverty, but still with limited resources, could be offered the option of buying into this extended insurance. At some point, the Medicare enrollee would have to bear the full cost of the premium—or accept a higher Part B deductible in order to obtain the long-term care option.



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